OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT DELIVERED AND ENTERED DECEMBER 29, 2009

LITTLE ROCK CARDIOLOGY CLINIC PA, et al., Plaintiffs-Appellants,

vs.

BAPTIST HEALTH; Baptist Medical System HMO, Inc., Defendants-Appellees, Arkansas Blue Cross and Blue Shield; USAble Corporation; HMO Partners, Inc., Defendants.

Nos. 08-3158/09-1786

591 F.3D 591

Appeal from the United States District Court for the Eastern District of Arkansas, Little Rock Cardiology Clinic, P.A. v. Baptist Health, 573 F. Supp. 2d 1125, NO. 4:06CV01594 JLH (E.D. Ark. 2008).

Before HON. MICHAEL J. MELLOY, HON. C. ARLEN BEAM, and RAYMOND W. GRUENDER, Circuit Judges.

OPINION: MELLOY, Circuit Judge.

This is an antitrust case involving alleged violations of Sections 1 and 2 of the Sherman Act, *15 U.S.C. §§ 1, 2*. It comes to us after the district court[1] granted Appellee Baptist Health's motion to dismiss

for failure to state a claim and denied Baptist Health's motion to tax discovery-related copying costs. The principal issue on appeal concerns the proper methodology for determining the relevant market in an antitrust case. We also address whether the district court abused its discretion in declining to tax costs. We affirm on both issues.

1 The Honorable J. Leon Holmes, Chief Judge, United States District Court for the Eastern District of Arkansas.

I. Background

Appellant Little Rock Cardiology Clinic PA ("LRCC") is a professional association of cardiologists located in Little Rock, Arkansas, practicing in both diagnostic and interventional cardiology procedures. Baptist Health is the largest hospital company in Arkansas, operating five hospitals in the state, its largest being a 585-bed facility in Little Rock. Blue Cross & Blue Shield of Arkansas ("Blue Cross") is a health-insurance company headquartered in Little Rock.[2] Beginning in 1975, LRCC and its cardiologists maintained clinical and staff privileges at Baptist Health and were in Blue Cross's FirstSource network, a network of preferred providers used by all of Blue Cross's health plans. This changed, however, with the opening of the Arkansas Heart Hospital.

2 Prior to oral argument, LRCC and Blue Cross settled their dispute. Blue Cross is no longer a party to this appeal.

In 1997, LRCC developed Arkansas Heart Hospital, which specializes in cardiology services and com-

petes with Baptist Health. Prior to developing Arkansas Heart, the LRCC cardiologists were on staff at Baptist Health, and participated in Blue Cross's FirstSource network. Shortly after LRCC opened Arkansas Heart, Blue Cross terminated its network provider agreements with LRCC and LRCC's doctors. LRCC alleges that Baptist Health effected this termination "in concert and in combination with . . . Baptist Health to restrain and monopolize trade unlawfully, specifically, to protect Baptist Health from competition in the relevant market." In 2003, Baptist Health adopted an "Economic Credentialing Policy," which prohibited any doctor from maintaining staff privileges at any Baptist Health facility if that doctor directly or indirectly held an interest in a competing hospital. Recently, an Arkansas state circuit court permanently enjoined enforcement of this policy.

LRCC initially filed this suit against Baptist Health in November 2006, alleging that Baptist Health conspired with Blue Cross to restrain trade in, and monopolize the market for, cardiology services for privately insured patients by: (1) forming a jointly owned HMO, HMO Partners, Inc., with Blue Cross; (2) agreeing with Blue Cross that Baptist Health would be the HMO's exclusive in-network facility; and (3) agreeing with Blue Cross that Blue Cross would remove LRCC from Blue Cross's FirstSource network. A month later, LRCC amended its complaint to add as plaintiffs a number of individual cardiologists and each of their individual professional associations through which they and LRCC provide cardiology services. Baptist Health then moved to dismiss the complaint for failure to state a claim. The district court denied the motion.

In December 2007, LRCC filed a second amended complaint, adding Blue Cross as a defendant, as well as Blue Cross's and Baptist Health's individually owned subsidiaries and their jointly owned subsidiary. [3] All defendants then moved to dismiss the second amended complaint for failure to state a claim. The district court granted this motion on the grounds that, among other things, LRCC's complaint failed to allege a proper relevant market. In doing so, the district court noted that the Supreme Court's recent decision in *Bell Atlantic Corp. v. Twombly, 550 U.S. 544, 127 S. Ct. 1955, 167 L. Ed. 2d 929 (2007)*, had created a higher pleading standard than the standard in *Conley v. Gibson, 355 U.S. 41, 78 S. Ct. 99, 2 L. Ed. 2d 80 (1957)*, the standard upon which the district court had relied in denying Baptist Health's first motion to dismiss. The district court, however, granted LRCC leave to amend its complaint one final time.

> 3 For the purpose of this opinion, we refer to the parties as "Baptist Health" or "Blue Cross." The identities of the subsidiaries are not material to our decision.

In March 2008, LRCC filed a third amended complaint, the complaint at issue in this appeal, alleging six antitrust claims against Baptist Health. [4] Count I alleges, under *§ 1* of the Sherman Act, that Baptist Health and Blue Cross unlawfully conspired to restrain trade in the market for services to cardiology patients. The remaining counts allege violations of *§ 2 of the Sherman Act*. Counts II and III allege that Baptist Health conspired with Blue Cross to monopolize, and attempted to monopolize, the market for cardiology procedures. Count IV alleges that Baptist

Health monopolized the market for cardiology procedures. Counts V and VI allege that Baptist Health conspired with Blue Cross to monopolize, and aided in Blue Cross's attempt to monopolize, the market for private health insurance.

> 4 We note that the third amended complaint contains two additional counts, Counts VII and VIII. Count VII alleges that Blue Cross monopolized the insurance market. It does not name Baptist Health, and is not a subject of this appeal. Count VIII seeks injunctive relief, which the district court rejected as barred by laches. LRCC waived any review of this holding by not raising the issue in its appellate brief. *Ballard v. Heineman, 548 F.3d 1132, 1136 (8th Cir. 2008)*. Thus, these counts are immaterial to our analysis.

The district court granted Baptist Health's motion to dismiss with prejudice, finding that the alleged relevant market for Counts I-IV was legally flawed and therefore Counts I-IV did not state a plausible antitrust claim. As to Counts V and VI, the district court dismissed LRCC's claims against Baptist Health as barred by the statute of limitations because LRCC failed to allege an overt act in furtherance of the conspiracy or attempt to monopolize the private insurance market within the four-year limitations period. See *15 U.S.C. § 15b*.

After the district court dismissed LRCC's complaint, Baptist Health filed a bill of costs under *Federal Rule of Civil Procedure 54(d)*, seeking discovery-related costs for transcription, in-house copying of documents, scanning documents produced in discov-

ery, and reproduction of Electronically Stored Information ("ESI"). The district court declined to tax those costs against LRCC.

On appeal, we address two issues: (1) whether the district court erred in dismissing Counts I-IV; and (2) whether the district court erred in declining to tax Baptist Health's discovery-related costs. Because LRCC does not raise on appeal the district court's dismissal, on limitations grounds, of Counts V and VI, we do not address it here. See *United States v. Azure, 539 F.3d 904, 912 (8th Cir. 2008).*

II. Antitrust Claims

On appeal, we review de novo the district court's grant of a motion to dismiss under *Federal Rule of Civil Procedure 12(b)(6),* "accepting the allegations contained in the complaint as true and drawing all reasonable inferences in favor of the nonmoving party." *Express Scripts, Inc. v. Aegon Direct Mktg. Servs., Inc., 516 F.3d 695, 698 (8th Cir. 2008).* This standard requires us to determine whether the complaint "assert[s] facts that affirmatively and plausibly suggest that the pleader has the right he claims . . . rather than facts that are merely consistent with such a right." *Stalley v. Catholic Health Initiatives, 509 F.3d 517, 521 (8th Cir. 2007).*

The four counts at issue on appeal raise federal antitrust claims under *Sections 1* and *2* of the Sherman Antitrust Act. Under that Act, it is unlawful to contract or form a conspiracy "in restraint of trade or commerce among the several States," *15 U.S.C. § 1,* or to "monopolize or attempt to monopolize . . . any part of the trade or commerce among the several States," *15 U.S.C. § 2.* The parties agree that

LRCC has not alleged a per se violation. LRCC therefore has the burden of alleging a relevant market in order to state a plausible antitrust claim. *Double D. Spotting Serv., Inc. v. Supervalu, Inc., 136 F.3d 554, 560 (8th Cir. 1998)*. Without a well-defined relevant market, a court cannot determine the effect that an allegedly illegal act has on competition. See *FTC v. Freeman Hosp., 69 F.3d 260, 270-71 (8th Cir. 1995)*. Thus, as we have stated, "Antitrust claims often rise or fall on the definition of the relevant market." *Bathke v. Casey's Gen. Stores, Inc., 64 F.3d 340, 345 (8th Cir. 1995)*. A relevant market consists of both a product market and a geographic market. Id. We proceed by analyzing each of these required components.

A. Product Market

A court's determination of the limits of a relevant product market requires inquiry into the choices available to consumers. *Craftsmen Limousine, Inc. v. Ford Motor Co., 491 F.3d 380, 388 (8th Cir. 2007)*. The focus is on how "consumers will shift from one product to the other in response to changes in their relative costs." *SuperTurf, Inc. v. Monsanto Co., 660 F.2d 1275, 1278 (8th Cir. 1981)*. The relevant product market should include "products that have reasonable interchangeability for the purpose for which they are produced." *United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 404, 76 S. Ct. 994, 100 L. Ed. 1264 (1956)*. The district court found that Appellant's third amended complaint failed to allege a relevant product market because, among other reasons, the complaint erroneously defined the product market by how consumers pay for cardiology services. We agree.

The parties extensively brief the issue of what LRCC alleges to be the relevant product market. The complaint first states, "The relevant product is those medical services that cardiology patients receive exclusively in a hospital from a cardiologist." It also states, however, that "cardiology services and hospital services are not distinct products for the purposes of antitrust analysis." Finally, it states that the relevant product market is "the market for cardiology procedures obtained in hospitals by patients covered by private insurance." Thus, it is unclear whether LRCC is alleging a market in which there is a single, conjoined service--cardiology services obtained in hospitals--or a market in which there are two distinct and complementary services--hospital services and cardiology services. One issue on which the parties agree, however, is that the product market LRCC alleges is limited to patients covered by private insurance. We base our affirmance of the district court's product-market holding on this undisputed limitation.

LRCC proposes a market limited by how consumers pay for cardiology procedures. This theory lacks support in both logic and law. As stated above, the general issue when determining the relevant product market concerns the choices available to consumers. *Craftsmen Limousine, 491 F.3d at 388.* In this case--an exclusive-dealing case involving shut-out cardiologists--the relevant inquiry is whether there are alternative patients available to the cardiologists. See *Campfield v. State Farm Mut. Auto. Ins. Co., 532 F.3d 1111, 1119 (10th Cir. 2008)* ("When there are numerous sources of interchangeable demand, the plaintiff cannot circumscribe the market to a few buyers in an effort to manipulate those buyers' mar-

ket share."); *Stop & Shop Supermarket Co. v. Blue Cross & Blue Shield of R. I., 373 F.3d 57, 67 (1st Cir. 2004)* ("[T]he concern in an ordinary exclusive dealing claim by a shut-out supplier is with the available market *for the supplier.*"); *Brokerage Concepts, Inc. v. U.S. Healthcare, Inc., 140 F.3d 494, 514 (3d Cir. 1998)* (stating the "logical assumption that [a pharmacy] considers members of other prescription plans, or uninsured persons, completely interchangeable with [privately insured] members."). Thus, LRCC must look to alternative patients who are able to pay the required fees, not just those who pay using private insurance.

LRCC argues that the product market should be limited to patients using private insurance because private insurance and government insurance--the other primary method of payment--are not reasonably interchangeable. The trouble with this theory is that it analyzes the issue from the wrong side of the transaction. It may be true that, from the patient's perspective, private insurance and Medicare/Medicaid are not reasonably interchangeable. For a variety of reasons, including age and financial considerations, a person with private insurance may not qualify for these government programs. But this lawsuit is not about the options available to patients, it is about the options available to shut-out cardiologists. LRCC's claims boil down to the allegation that, due to Baptist Health's allegedly unlawful actions, LRCC has access to fewer patients. The relevant question, then, is to whom might the cardiologists at LRCC potentially provide medical service? LRCC's complaint provides the answer: LRCC can provide service to "patients . . . from either a government program such as Medicare or Medicaid, *or* from a

private insurer." (emphasis added). Patients able to pay their medical bill, regardless of the method of payment, are reasonably interchangeable from the cardiologist's perspective--the correct perspective from which to analyze the issue in this case.

In reaching this conclusion we do not, as LRCC argues, disregard the well-pleaded allegations in the complaint. LRCC has made no allegation that private insurance is the only method of payment it can accept. Quite the opposite, LRCC's complaint states both that it can and that it does accept payment from sources other than private insurers. Our conclusion does not challenge LRCC's factual allegations, but rather its legal theory, to which we owe no deference. *Wiles v. Capitol Indem. Corp., 280 F.3d 868, 870 (8th Cir. 2002)*. Nor, as LRCC contends, does our decision in *F.T.C. v. Tenet Health Care Corp., 186 F.3d 1045 (8th Cir. 1999)*, endorse LRCC's proposed market. Tenet was a monopolization case brought under *§ 7* of the Clayton Act, *15 U.S.C. § 18*, in which we addressed the bounds of a relevant geographic market. *Tenet, 186 F.3d at 1051-52*. In so doing, we found only that the locations where a patient with private insurance could reasonably turn (a key inquiry in geographic-market analysis) were constrained by whether the patient's insurance covered the hospital in the relevant location. *Id. at 1055*. This does not address the inquiry in the case of a shut-out supplier: to whom can the supplier sell? Thus, Tenet is inapposite to our decision on the relevant product market in this case.

We conclude that, as a matter of law, in an antitrust claim brought by a seller, a product market cannot be limited to a single method of payment

when there are other methods of payment that are acceptable to the seller. We also analyze LRCC's alleged relevant geographic market as an alternative ground on which to affirm the district court's dismissal.

B. Geographic Market

LRCC's failure to allege a coherent relevant geographic market provides an adequate and independent means of affirming the district court's dismissal. Properly defined, a geographic market is a geographic area "in which the seller operates, and to which . . . purchaser[s] can practicably turn for supplies." *Tampa Elec. Co. v. Nashville Coal Co., 365 U.S. 320, 327, 81 S. Ct. 623, 5 L. Ed. 2d 580 (1961)*; accord *Morgenstern v. Wilson, 29 F.3d 1291, 1296 (8th Cir. 1994)*. Broken down, the test requires a court to first determine whether a plaintiff has alleged a geographic market that includes the area in which a defendant supplier draws a sufficiently large percentage of its business--"the market area in which the seller operates," its trade area. See *Morgenstern, 29 F.3d at 1296* (citation omitted); *Double D, 136 F.3d at 560*; *Bathke, 64 F.3d at 345*. A court must then determine whether a plaintiff has alleged a geographic market in which only a small percentage of purchasers have alternative suppliers to whom they could practicably turn in the event that a defendant supplier's anticompetitive actions result in a price increase. See, e.g., *Morgenstern, 29 F.3d at 1296*. The end goal in this analysis is to delineate a geographic area where, in the medical setting, "'few' patients leave . . . and 'few' patients enter." *United States v. Rockford Mem'l Corp., 717 F. Supp. 1251, 1267 (N.D. Ill. 1989)*, aff'd, *898 F.2d 1278 (7th Cir.*

1990). The district court held that LRCC's alleged geographic market, Little Rock, was overly narrow because the complaint contains no allegations that Little Rock, by itself, made up Baptist Health's trade area. As with the product market, we agree with the district court.

LRCC's complaint alleges that Baptist Health operates and competes in an area well beyond the city of Little Rock. The complaint alleges that Baptist Health serves "a large percentage of residents from around the state who need cardiology services in hospitals." More specifically, the complaint alleges that, in addition to Little Rock, Baptist Health operates in Hot Springs, Pine Bluff, Conway, Searcy, and El Dorado. Despite these allegations detailing the apparently broad reach of Baptist Health's cardiology services, LRCC's complaint seeks to limit the relevant geographic market to "the cities of Little Rock and North Little Rock." The geographic market is defined as such, LRCC contends, because cardiology patients in Little Rock and patients from hospitals in surrounding areas "overwhelmingly" go to Little Rock for cardiology procedures. [5] The reason for this migration to Little Rock, LRCC alleges, is that the cardiology procedures are "not practicably available in hospitals in surrounding cities." In short, LRCC's argument is that Little Rock is the relevant geographic market because it is the location to which would-be cardiology patients must travel. Accepting the allegations as true and reading them in the light most favorable to LRCC, as we must, *Express Scripts, 516 F.3d at 698*, we cannot find that LRCC's complaint alleges a plausible relevant geographic market.

> 5 LRCC's complaint alleges that "99.5% of privately insured cardiology patients from the area code with zip codes beginning with the three digits 722, which is Little Rock proper, use hospitals within Little Rock." Further, "[o]f the privately insured cardiology patients who reside in Little Rock and its surrounding areas, which are covered by zip codes that begin with 722 and 721, 84.7% use hospitals in Little Rock. The remaining 15.3% of cardiology patients in these zip codes use hospitals in North Little Rock and Conway."

This case presents an unusual question. Our cases typically have addressed disputes raising the issue of where a consumer can practicably turn in the event of a defendant's anticompetitive price increase--the second prong in our two-prong geographic-market analysis. See, e.g., *Minn. Ass'n of Nurse Anesthetists v. Unity Hosp., 208 F.3d 655, 662 (8th Cir. 2000)*; *Tenet, 186 F.3d at 1054*; *Double D, 136 F.3d at 560-61*; *Bathke, 64 F.3d at 344-47*; *Morgenstern, 29 F.3d at 1296*. Here, however, LRCC's complaint contains allegations concerning the geographic areas where customers could turn for cardiology procedures, but fails to do so from the starting point of Baptist Health's trade area. In other words, LRCC's complaint alleges that a low percentage of patients leave its proposed geographic market, but does not allege that a low percentage of its patients enter its proposed geographic market. Without the necessary allegations, we cannot find that LRCC has stated a plausible antitrust claim. By limiting the geographic market in this way, LRCC is able to gerrymander the relevant market to an artificially narrow location, the location where cardiology proce-

dures take place. As the Supreme Court has stated, *Tampa, 365 U.S. at 327*, and as we have echoed, *Double D, 136 F.3d at 560*, this is an impermissible limitation. An antitrust plaintiff must allege a geographic market in which the defendant supplier draws a sufficiently large percentage of its business. This crucial first step serves as a limitation, preventing antitrust plaintiffs from delineating arbitrarily narrow geographic markets. It is on this first step that LRCC's complaint stumbles.

Adopting LRCC's theory of a geographic market has the potential to create problems in antitrust cases where the product or service at issue requires the consumer to travel to a specified location. It would, as the district court stated, allow antitrust plaintiffs to "define a market by identifying a small area around the defendant's location in which nearly all potential customers patronize the defendant." Using LRCC's logic, we could delineate the relevant geographic market as the square mile surrounding a hospital, the block on which a hospital sits, or even a hospital building where the relevant procedure takes place. Surely a sufficiently large percentage of people in this area use the hospital's services. These "geographic markets," however, are obviously too narrow.

LRCC next argues that relevant case law does not permit us to hold that a single city is not a relevant market. This argument is problematic for two reasons. First, although we find that the geographic market in this case is implausibly narrow, our opinion should not be read to reject the notion that a city by itself could, in a different case, be a relevant geographic market. The boundaries of a relevant market will turn on the factual allegations presented in any

given case. *Tenet, 186 F.3d at 1052.* We hold only that in this case, the theory upon which LRCC relies to reach the conclusion that a single city is the relevant geographic market is legally flawed.

Second, the cases from the Seventh Circuit, which LRCC cites in support of its position, are not contrary to our ruling in this case. The first case, *United States v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir. 1990)*, is in fact similar to our holding in regard to its analysis of the relevant product market, and does not support LRCC's argument. In Rockford, the Seventh Circuit noted first that the district court found that 87 percent of defendants' patients came from "an area surrounding Rockford and consisting of the rest of Winnebago County (the county in which Rockford is located) and pieces of several other counties." *Id. at 1284.* Thus, Rockford first noted the defendant's trade area. The court then moved to the second prong of the analysis, stating that patients within this market were unlikely to seek out other hospitals in the event of anticompetitive pricing and therefore upheld it as the relevant geographic market. *Id. at 1285.* This is not analogous to LRCC's case. Rather than arguing that the vast majority of Baptist Health's patients come from Little Rock, which would be analogous to Rockford, LRCC supports its geographic market with the allegation that the vast majority of cardiology patients go to hospitals in Little Rock. The distinction between these two scenarios is not without a difference. As stated above, were we to adopt LRCC's logic, we would be opening the door to creation of geographic markets with narrowness limited only by antitrust plaintiffs' imagination. We refuse to do this.

The second case on which LRCC relies, *Hospital Corp. of America v. F.T.C., 807 F.2d 1381 (7th Cir. 1986)*, is equally unavailing. Because market definition was not at issue in that case, see *id. at 1388*, it stands for no more than that a city could, given the right allegations, be a relevant geographic market. [6] We do not dispute this conclusion, nor does it affect our analysis in this case.

> 6 In addition, LRCC cites a series of district court cases in support of their relevant geographic market. See *United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 141-42 (E.D.N.Y. 1997)*; *HTI Health Servs., Inc. v. Quorum Health Group, Inc., 960 F. Supp. 1104, 1126 (S.D. Miss. 1997)*; *Santa Cruz Med. Clinic v. Dominican Santa Cruz Hosp., No. C93 20613 RMW, 1995 WL 853037, at *8-11 (N.D. Cal. Sept. 7, 1995)*. These cases stand only for the proposition that, given the correct allegations, a small city area can constitute a relevant geographic market and are therefore not helpful to LRCC. In fact, Santa Cruz Med., cuts against LRCC, as it notes, "Ideally, an area should be defined where few patients leave an area *and* few patients enter an area to obtain hospital services." *1995 U.S. Dist. LEXIS 21032, [WL] at *8* (emphasis added).

Moreover, we do not mean to endorse the idea that a firm's trade area is equivalent to a relevant geographic market. There is voluminous case law cautioning against such a holding. See, e.g., *Bathke, 64 F.3d at 346*; *Unity Hosp., 208 F.3d at 662*; *Gordon v. Lewistown Hosp., 423 F.3d 184, 212 (3d Cir. 2005)*; *Surgical Care Ctr. of Hammond, L.C. v. Hosp. Serv.*

Dist. No. 1 of Tangipahoa Parish, 309 F.3d 836, 840 (5th Cir. 2002); see also Herbert Hovenkamp, Federal Antitrust Policy, § 3.6d, at 119 (3d ed. 2005) ("'trade area' and the 'relevant market' are precisely reverse concepts"). Because plaintiffs must identify consumers' alternatives, the relevant geographic market will often be larger than a firm's trade area. This well-established principle does not alter our holding. We hold only that where, as here, an antitrust plaintiff alleges that a firm competes in and draws its customers from a specified geographic area, it cannot then limit the relevant geographic market to a location smaller than that area based solely on the fact that consumers must travel to that smaller area to obtain the relevant service or product. To do so would allow antitrust plaintiffs to gerrymander the relevant geographic markets into artificially narrow locations, as LRCC has attempted to do here.

We are well aware of our court's reluctance to dismiss antitrust complaints before the parties have had an opportunity to fully conduct discovery. *Huelsman v. Civic Ctr. Corp., 873 F.2d 1171, 1174 (8th Cir. 1989)* (stating that a "dismissal . . . on the pleadings should be 'granted sparingly and with caution.'") (citation omitted). However, more discovery in this case could not cure the defects in LRCC's legal theory as to either the relevant product or geographic market. Without a showing as to the proper relevant market, LRCC cannot establish the necessary predicate for their antitrust claims. For this reason, we affirm the district court's dismissal of LRCC's antitrust claims.

III. Costs Claim [7]

7 On July 16, 2009, LRCC submitted to us, pursuant to *Federal Rule of Civil Procedure 28(j)*, a letter indicating that Baptist Health should be judicially estopped from seeking discovery-related copying costs because it had previously argued that such costs are not taxable. See *Platte River Ins. Co. v. Baptist Health, et al., No. 4:07cv0036 SWW, 2009 U.S. Dist. LEXIS 64197, 2009 WL 2044610 (E.D. Ark. July 10, 2009)*. Because LRCC's previous position took place in an unrelated proceeding against a different party, we find that Baptist Health is not estopped from taking its current position. See *Hossaini v. W. Mo. Med. Ctr., 140 F.3d 1140, 1142 (8th Cir. 1998)* ("The doctrine of judicial estoppel prohibits a party from taking inconsistent positions in the same or related litigation.").

Rule 54(d) of the Federal Rules of Civil Procedure gives district courts the power to tax costs in favor of a prevailing party. These awards, however, must fit within *28 U.S.C. § 1920*, which enumerates the costs that a district court may tax. *Crawford Fitting Co. v. J.T. Gibbons, Inc., 482 U.S. 437, 441-42, 107 S. Ct. 2494, 96 L. Ed. 2d 385 (1987)*. The section at issue in this case, *§ 1920(4)*, states that a judge may tax "costs of making copies of any materials where the copies are necessarily obtained for use in the case." District courts have broad discretion over the award of costs to a prevailing party under *§ 1920*, and we review such a decision for abuse of discretion. *Zotos v. Lindbergh Sch. Dist., 121 F.3d 356, 363 (8th Cir. 1997)*. "An abuse of discretion occurs where the district court rests its conclusion on clearly erroneous

factual findings or erroneous legal conclusions." *Lankford v. Sherman, 451 F.3d 496, 503-04 (8th Cir. 2006)*. Here, the district court declined to tax as costs Baptist Health's expenses related to copying documents to be produced in discovery. Baptist Health cross-appeals this holding and, in the event we reverse the district court, argues that costs for scanning documents and reproducing Electronically Stored Information ("ESI") fall within "copies of any materials" as used in *§ 1920(4)*. Because there is no allegation of erroneous factual findings, we address whether the district court's holding hinges on erroneous legal conclusions.

The threshold issue here is whether the district court erred in declining to tax discovery-related copying expenses. It is unclear whether the district court ruled as a matter of law or as a matter of its discretion. We believe, however, that it is fair to read the opinion as an exercise of the district court's discretion. Therefore, we confine our holding to the conclusion that the district court did not abuse its discretion. We reach this conclusion for two reasons.

First, Baptist Health does not cite, nor are we aware of, any decision that *requires* a district court to tax discovery-related expenses. We note that there are cases suggesting that a district court may tax costs for discovery-related copying. See, e.g., *Slagenweit v. Slagenweit, 63 F.3d 719, 721 (8th Cir. 1995)* (per curiam) (upholding award of costs for a deposition copy, despite the fact that the deposition was not introduced at trial). These cases are at most permissive, and do not compel the district court to tax such costs. Moreover, cases from other circuits that have explicitly addressed discovery-related copying costs

have done so only to the extent that they have found a district court did not abuse its discretion in taxing such costs. See, e.g., *E.E.O.C. v. W&O, Inc., 213 F.3d 600, 623 (11th Cir. 2000)*; *Illinois v. Sangamo Const. Co., 657 F.2d 855, 867 (7th Cir. 1981)*.

Second, numerous district courts within the Eighth Circuit have refused to tax discovery-related copying costs. See, e.g., *Jones v. Nat'l Am. Univ., No. CIV. 06-5075-KES, 2009 U.S. Dist. LEXIS 60854, 2009 WL 2005293, at *6 (D.S.D. July 8, 2009)* (stating that copies of papers "necessarily obtained for use in the case" covers only the "cost of actually trying a case in the courtroom"); *Moore v. Daimler-Chrysler Corp., No. 4:06CV757 CDP, 2007 U.S. Dist. LEXIS 34756, 2007 WL 1445591, at *1 (E.D. Mo. May 11, 2007)* (same); *Sphere Drake Ins. PLC v. Trisko, 66 F. Supp. 2d 1088, 1093-94 (D. Minn. 1999)* (same); *Emmenegger v. Bull Moose Tube Co., 33 F. Supp. 2d 1127, 1133-34 (E.D. Mo. 1998)* (same). Given this, we cannot find that the district court abused its discretion. Because we affirm the district court on this threshold issue, we do not reach the issue of whether costs for scanning documents and reproducing ESI are taxable under *§ 1920(4)*.

IV. Conclusion

For the foregoing reasons, we affirm the district court on both the antitrust and costs claims.

OPINION OF UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF ARKANSAS DELIVERED AND ENTERED AUGUST 29, 2008

LITTLE ROCK CARDIOLOGY CLINIC, PA, et al., Plaintiffs

vs.

BAPTIST HEALTH; Arkansas Blue Cross and Blue Shield; USAble Corporation; Baptist Medical System HMO, Inc.; and HMO Partners, Inc., Defendants

NO. 4:06CV01594 JLH

573 F. Supp. 2d 1125

Before HON. J. LEON HOLMES, District Judge.

OPINION AND ORDER

This is an antitrust case alleging violations of *sections 1* and *2* of the Sherman Act, *15 U.S.C. §§ 1* and *2*. The plaintiffs seek treble damages under *section 4* of the Clayton Act, *15 U.S.C. § 15*, and injunctive relief under *section 16* of the Clayton Act, *15 U.S.C. § 26*. The complaint was initially filed by Little Rock Cardiology Clinic, P.A., against Baptist Health on November 2, 2006. Little Rock Cardiology Clinic, as the name indicates, is a professional association of cardiologists practicing medicine in Little Rock. Baptist Health is a nonprofit corporation that operates five hospitals in Arkansas, including one in Little Rock and one in North Little Rock.

Although the initial complaint named only Baptist Health as a defendant, it alleged that Arkansas Blue Cross and Blue Shield, a nonprofit mutual insurance company, and Baptist Health conspired to restrain trade in, and to monopolize the market for, cardiology services for privately insured patients in a sixteen county area of central Arkansas in violation of *sections 1* and *2* of the Sherman Act. The complaint also alleged that Baptist Health attempted to monopolize and has monopolized the same market. Before Baptist Health responded to the complaint, an amended complaint was filed, making substantially the same allegations as the initial complaint except that seven of the physicians who practice with Little Rock Cardiology Clinic, and their individual professional associations, were added as plaintiffs. A little more than a year after the initial complaint was filed, the plaintiffs moved for leave to file a second amended complaint, and that motion was granted. The second amended complaint added as defendants Arkansas Blue Cross and Blue Shield, USAble Corporation, Baptist Medical System HMO, Inc., and HMO Partners, Inc. USAble Corporation is a wholly-owned subsidiary of Arkansas Blue Cross and Blue Shield. HMO Partners, Inc., which is owned by Baptist Medical System HMO, Inc., and USAble Corporation, operates an HMO named Health Advantage.[1] The defendants then moved to dismiss the second amended complaint for failure to state a claim upon which relief can be granted. The Court concluded that the second amended complaint failed to state a claim upon which relief could be granted but, over the defendants' objections, gave the plaintiffs leave to file a third amended complaint.

The plaintiffs filed their third amended complaint on March 27, 2008.

> 1 This opinion will refer to Arkansas Blue Cross and Blue Shield, USAble Corporation, and HMO Partners, Inc., collectively as "Blue Cross," unless expressly stated or the context indicates otherwise.

The alleged wrongdoing for which the plaintiffs seek relief in this case began as a response to the opening of the Arkansas Heart Hospital in Little Rock in 1997. The owners of that hospital included cardiologists who practiced at Little Rock Cardiology Clinic, who were on staff at the Baptist Hospital in Little Rock, and who participated in the Arkansas FirstSource network. FirstSource was a network of providers used by all of the health plans offered by Blue Cross and its affiliates. Shortly after Arkansas Heart Hospital opened, the Little Rock Cardiology Clinic and the doctors who practiced there were excluded from the FirstSource network. According to the third amended complaint, the cardiologists at the Little Rock Cardiology Clinic are the only specialists in the state of Arkansas excluded from that network. The motive for excluding them from the network, according to the third amended complaint, was to protect Baptist Health from competition by Arkansas Heart Hospital. Further, in May 2003, Baptist Health adopted an "economic credentialing policy" to prohibit any doctor from having or maintaining staff privileges at any Baptist Health facility if that doctor directly or indirectly holds an interest in a competing hospital, which is defined as any hospital in the state of Arkansas. The enforcement of that policy was preliminarily enjoined in February 2004 and has not

been enforced since then. *See Baptist Health v. Murphy, 365 Ark. 115, 226 S.W.3d 800 (2006).* [2]

2 For opinions in previous actions filed in federal court, *see Ark. Blue Cross & Blue Shield v. St. Vincent Infirmary Med. Ctr., No. 4:07CV00813, 2007 U.S. Dist. LEXIS 92101, 2007 WL 4287842 (E.D. Ark. Dec. 5, 2007)*; *Ark. Blue Cross & Blue Shield v. St. Vincent Infirmary Med. Ctr., No. 4:03CV00662, 2006 U.S. Dist. LEXIS 22024, 2006 WL 796949 (E.D. Ark. Mar. 27, 2006)*; *Murphy v. Baptist Health, No. 4:04CV0112, 2004 U.S. Dist. LEXIS 12080, 2004 WL 1474655 (E.D. Ark. Feb. 24, 2004).*

The third amended complaint alleges seven claims for relief under the Sherman Act. Count I alleges that the defendants have engaged in an unlawful contract combination, concerted action, or conspiracy to exclude competition and unreasonably restrain interstate commerce in a market for services to cardiology patients in violation of *section 1 of the Sherman Act*. Counts II, III, and IV allege a conspiracy to monopolize, attempt to monopolize, and monopolization of a market for services to cardiology patients in violation of *section 2* of the Sherman Act. The claims for relief alleged in Counts I-IV are the same claims for relief that were alleged in the first three versions of plaintiffs' complaint. The new claims for relief alleged for the first time in the third amended complaint are Counts V, VI, and VII, which allege a conspiracy to monopolize, attempt to monopolize, and monopolization of a market for private health insurance in violation of *section 2* of the Sherman Act. The third amended complaint also added Count VIII, which seeks injunctive relief.

The defendants have moved to dismiss the third amended complaint pursuant to *Rule 12(b)(6) of the Federal Rules of Civil Procedure*. Baptist Health [3] argues, in part, that the case cannot be allowed to go forward based on the third amended complaint because the relevant market alleged is incoherent and therefore incapable of forming the basis on which adjudication of these antitrust claims can proceed. Blue Cross joins to a large extent in the arguments of Baptist Health but also contends that the claims against it are barred by the statute of limitations. Baptist Health, in turn, has adopted by reference Blue Cross's arguments as to the statute of limitations. All defendants argue that these plaintiffs have no standing to assert the *section 2* claims pertaining to insurance services. [4]

> 3 "Baptist Health" in this opinion will include the wholly-owned subsidiary, Baptist Medical System HMO, Inc., unless expressly stated or the context indicates otherwise.
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> 4 Because Counts V-VII are dismissed on other grounds, the Court will not address the issue of whether the plaintiffs have standing to assert the *section 2* claims pertaining to insurance services.

The Court has concluded that all of the plaintiffs' damages claims are barred by the statute of limitations except the claims against Baptist Health asserted in Counts I-IV; and that plaintiffs' claims for injunctive relief are barred by laches. The Court has also concluded that the relevant market alleged for Counts I-IV in the third amended complaint is, indeed, incoherent, and that this incoherence results not from inadequate draftsmanship or the absence of

discovery but from an incurable defect in the legal theory; which is to say that the Court does not believe that the deficiencies can be cured by further amendment. Therefore, the third amended complaint in its entirety will be dismissed with prejudice.

I. THE STANDARD FOR RULING ON A 12(b)(6) MOTION

Rule 8(a) of the Federal Rules of Civil Procedure provides that a pleading that states a claim for relief must contain a short and plain statement of the claim showing that the pleader is entitled to relief. *Rule 12(b)(6)* authorizes a party to move to dismiss an action based upon the failure to state a claim upon which relief can be granted. The pleading must "'give the defendant fair notice of what the . . . claim is and the grounds upon which it rests.'" *Bell Atlantic Corp. v. Twombly, 550 U.S. 544, 127 S. Ct. 1955, 1964, 167 L. Ed. 2d 929 (2007)* (quoting *Conley v. Gibson, 355 U.S. 41, 47, 78 S. Ct. 99, 2 L. Ed. 2d 80 (1957))*. Although *Rule 8(a)(2)* does not require detailed factual allegations, that rule does require "more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Id. at 1965*. "While the court must accept allegations of fact as true when considering a motion to dismiss, the court is free to ignore legal conclusions, unsupported conclusions, unwarranted inferences and sweeping legal conclusions cast in the form of factual allegations." *Wiles v. Capitol Indem. Corp., 280 F.3d 868, 870 (8th Cir. 2002)*; *see also Taxi Connection v. Dakota, Minn. & Eastern R.R. Corp., 513 F.3d 823, 826 (8th Cir. 2008)* (stating that the court is not required to accept "mere conclusions" alleged in the complaint). "The plaintiff must assert facts

that affirmatively and plausibly suggest that the pleader has the right he claims . . . rather than facts that are merely consistent with such a right." *Stalley ex rel. U.S. v. Catholic Health Initiative, 509 F.3d 517, 521 (8th Cir. 2007)* (citing *Twombly, 127 S. Ct. at 1964-66*).

II. THE STATUTE OF LIMITATIONS

Actions seeking damages pursuant to *section 4* of the Clayton Act are subject to the four-year statute of limitations provided in section 4B of the Clayton Act, *15 U.S.C. § 15b*. Here, the initial complaint, which was filed on November 2, 2006, named Baptist Health as the only defendant and asserted only the claims relating to the market for "cardiology services for privately insured individuals." Compl. PP 32, 37, 47, 54. On December 17, 2007, the plaintiffs filed their second amended complaint adding Arkansas Blue Cross and Blue Shield, USAble Corporation, Baptist Medical System HMO, Inc., and HMO Partners, Inc., as defendants. The claims relating to the market for health insurance were added in the third amended complaint, which was filed on March 27, 2008. The third amended complaint alleges that an illegal combination began no later than early 1997 (paragraph 131), that USAble Corporation terminated its contract with the plaintiffs in June of 1997 (paragraph 132), that HMO Partners terminated its contract with the plaintiffs in September of 1997 (paragraph 137), and that the defendants had acquired monopoly power in the hospital services and private insurance markets by 2001 (paragraph 82). All of these events occurred more than four years before the plaintiffs filed the original complaint on No-

vember 2, 2006, or the second amended complaint on December 17, 2007. [5]

> 5 For purposes of ruling on the motions to dismiss, the Court will assume, without deciding, that all claims relate back to the second amended complaint as to the defendants first named in that complaint and back to the original complaint as to Baptist Health. No argument is made that the claims against defendants other than Baptist Health relate back to the original complaint under *Fed. R. Civ. P. 15(c)(1)(C)*.

The plaintiffs argue that they have alleged facts to show a continuing conspiracy or continuing violation within four years of the filing of the complaint and the second amended complaint and, therefore, their claims are not barred by the statute of limitations.

The classic statement of the continuing violation doctrine is found in *Hanover Shoe, Inc. v. United Shoe Mach. Corp., 392 U.S. 481, 88 S. Ct. 2224, 20 L. Ed. 2d 1231 (1968)*. United monopolized the shoe machinery industry. Hanover was a shoe manufacturer and one of United's customers. Starting in 1912, United would not sell machinery to shoe manufacturers but, instead, used its monopoly power to require shoe manufacturers to lease its machinery. Hanover filed suit in 1955. In rejecting United's argument that Hanover's claim was barred by the statute of limitations, the Supreme Court said:

> United has also advanced the argument that because the earliest impact on Hano-

> ver of United's lease only policy occurred in 1912, Hanover's cause of action arose during that year and is now barred by the applicable Pennsylvania statute of limitations. The Court of Appeals correctly rejected United's argument in its supplemental opinion. We are not dealing with a violation which, if it occurs at all, must occur within some specific and limited time span. *Cf. Emich Motors Corp. v. General Motors Corp., 229 F.2d 714 (C.A.7th Cir. 1956)*, upon which United relies. Rather, we are dealing with conduct which constituted a continuing violation of the Sherman Act and which inflicted continuing and accumulating harm on Hanover. Although Hanover could have sued in 1912 for the injury then being inflicted, it was equally entitled to sue in 1955.

Id. at 502 n.15, 88 S. Ct. at 2236 n.15. The critical distinction made by the court in *Hanover Shoe* is the distinction between "a violation which, if it occurs at all, must occur within some specific and limited time span" and "conduct which constituted a continuing violation of the Sherman Act and which inflicted continuing and accumulating harm" on the plaintiff. The *Emich Motors* case -- which the court cited as an example of "a violation which, if it occurs at all, must occur within some specific and limited time span" -- was a case in which a dealer was terminated as part of a conspiracy between GM, GMAC, and others to control the financing of automobile purchases by compelling dealers to use the financing offered by

GMAC. *Emich Motors, 229 F.2d at 715.* The terse discussion in *Hanover Shoe* does not explain why a dealer termination, which results in an ongoing exclusion from a business relationship with the manufacturer, is an example of a violation "which . . . must occur within some specific and limited time." *Hanover Shoe, 392 U.S. at 502 n.15, 88 S. Ct. at 2236 n.15.*

The Eighth Circuit discussed the continuing violation theory in *Midwestern Machinery v. Northwest Airlines, 392 F.3d 265 (8th Cir. 2004).* Although the purpose of the discussion there was to explain why the continuing violation theory does not apply to a case alleging that a merger violated *section 7* of the Clayton Act, all parties have urged the Court to accept that case as controlling authority. The discussion in *Midwestern Machinery* begins with the observation that the typical antitrust continuing violation occurs in a price-fixing conspiracy actionable under *section 1* of the Sherman Act "when conspirators continue to meet to fine-tune their cartel agreement." *Id. at 269.* "These meetings are overt acts that begin a new statute of limitations because they serve to further the objections of the conspiracy." *Id.* Outside the context of a RICO or Sherman Act conspiracy, "new overt acts must be more than the unabated inertial consequences of the initial violation." *Id. at 270.* In explaining the distinction in footnote 15 of *Hanover Shoe, Midwestern Machinery* says that the Supreme Court "endorsed the Third Circuit's reasoning that United's conduct 'went beyond a mere continuation of the refusal to sell; it collected rentals on leases and entered into new leases when old machinery was no longer in working condition and required replacement.'" *Id.* (quoting *Hanover Shoe, Inc. v. United Shoe Mach. Corp., 377 F.2d 776, 794 (3d Cir. 1967),*

aff'd in part and rev'd in part, 392 U.S. 481, 88 S. Ct. 2224, 20 L. Ed. 2d 1231 (1968)). The distinction that *Midwestern Machinery* then draws is between actively using an unlawful policy to maintain a monopoly and passively implementing anti-competitive policies, such as a refusal to deal. *Id.* When the latter occurs, "[e]xisting competitors must act when a rival initiates anticompetitive policies that do not require additional anti-competitive action to implement[,]" because "implementation is only a reaffirmation of the policy's adoption, and the statute begins to run as soon as the competitor suffers injury." *Id.* As to the former, "[o]nly where the monopolist actively reinitiates the anti-competitive policy and enjoys benefits from that action can the continuing violation theory apply." *Id. at 271.* "This distinction between 'new and accumulating injury on the plaintiff' (which restart[s] the statute of limitations) and unabated inertial consequences of previous acts (which do not) allows the statute of limitations to have effect and discourages private parties from sleeping on their rights." *Id.* (citation omitted).

The other Eighth Circuit decisions that must be noted are *Lomar Wholesale Grocery v. Dieter's Gourmet Foods, Inc., 824 F.2d 582 (8th Cir. 1987);* and *Pioneer Co. v. Talon, Inc., 462 F.2d 1106 (8th Cir. 1972).*

In *Pioneer,* the plaintiff sold Talon's products at wholesale. When Talon learned that Pioneer was selling its products at discount prices, it refused to sell to Pioneer thereafter. The issue was whether the statute of limitations accrued when Talon gave notice to Pioneer that it would no longer sell products to it or when subsequent orders were refused. *Pio-*

neer, 462 F.2d at 1107. The Eighth Circuit held that the cause of action accrued when orders were refused, not when notice was given, because even though Talon gave notice that it would refuse future orders, "it terminated nothing of legal significance" because, unlike the plaintiff in *Emich Motors,* it had no contract to terminate. *Id. at 1108.*

In *Lomar Wholesale Grocery,* the Eighth Circuit again addressed the issue of when the cause of action of a terminated distributor accrued and held that the cause of action accrued when the termination first occurred, not on subsequent occasions when requests for reinstatement were denied. *Lomar Wholesale Grocery, 824 F.2d at 586.* The court rejected the argument that the later denials of requests for reinstatement were tantamount to refusal to fill orders that had been placed subsequent to notice of termination, which *Pioneer* found would start the period of limitations anew. *Id.* In rejecting the analogy with *Pioneer,* the court said that refusing a specific order was a "fresh instance" of a refusal to deal whereas declining a request for reinstatement as a distributor was "'merely the abatable but unabated inertial consequences'" of conduct that occurred outside the period of limitations and therefore conduct that did not give rise to a new cause of action. *Lomar Wholesale Grocery, 824 F.2d at 586.* (quoting *Poster Exch., Inc. v. Nat'l Screen Serv. Corp., 517 F.2d 117, 128 (5th Cir. 1975)).*

Pioneer and *Lomar Wholesale Grocery* are more pertinent to the case at hand than many cases that the parties have cited because they are cases in which the injury to the plaintiff was caused by a refusal to deal, which is the situation here. Although

the plaintiffs have asserted *section 2* claims for monopolization, attempt to monopolize, and conspiracy to monopolize, the injury to them -- the injury that gives rise to their claims for damages and for which they seek injunctive relief -- is a refusal to deal. As noted above, the third amended complaint alleges that USAble, acting for Blue Cross, terminated its network provider agreements with Little Rock Cardiology Clinic and its doctors in June 1997, while HMO Partners did so in September 1997. That there were provider agreements that were terminated distinguishes this case from *Pioneer*, where "nothing of legal significance" was terminated.

With this discussion of the case law in mind, we turn to the acts that the plaintiffs allege show a continuing violation within four years of the filing of the complaint and the second amended complaint.

A. WHETHER PLAINTIFFS' CLAIMS ARE BARRED BY LIMITATIONS AS TO DEFENDANTS OTHER THAN BAPTIST HEALTH

The plaintiffs first argue that an overt act occurred in January 2006 when they were allowed back into some but not all of the network. Understanding the plaintiffs' argument, as well as the reason why that argument fails, requires some historical background.

The Arkansas General Assembly enacted the Arkansas Patient Protection Act of 1995, *Ark. Code Ann. § 23-99-201 et seq.*, popularly known as the "any willing provider" statute, in 1995. That statute prohibited insurers from using monetary incentives or penalties to affect a health plan beneficiary's choice of health care provider, and it required that every qualified health care provider who is willing to accept a health plan's terms, conditions, and fee schedule be allowed to participate. *Ark. Code Ann. § 23-99-204*. The statute excluded self-funded or other health benefit plans that are exempt from state regulation by virtue of ERISA. *ARK. CODE ANN. § 23-99-209*. On January 31, 1997, this Court entered an order permanently enjoining enforcement of that Act on the grounds that it was preempted by ERISA. *See Prudential Ins. Co. of America v. Nat'l Park Med. Ctr., Inc., 964 F. Supp. 1285 (E.D. Ark. 1997)*. Shortly thereafter, this Court entered an amended order stating that the any willing provider statute was preempted only as related to ERISA plans. On appeal, the Eighth Circuit held that the any willing provider statute was preempted in its entirety by ERISA, not only as it related to ERISA plans. *Prudential Ins. Co. of America v. Nat'l Park Med. Ctr.,*

Inc., 154 F.3d 812 (8th Cir. 1998). On April 2, 2003, the Supreme Court held that a similar statute in Kentucky was not preempted. *Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 123 S. Ct. 1471, 155 L. Ed. 2d 468 (2003).* Ultimately, on August 2, 2005, this Court lifted the injunction against enforcement of the any willing provider statute except with respect to self-funded ERISA plans and certain civil penalties.

According to paragraph 164 of the third amended complaint, after the injunction against enforcement of the any willing provider statute was lifted, in January 2006 the plaintiffs were allowed back into the network with Arkansas Blue Cross and Blue Shield and HMO Partners but not as to "FirstSource or any network used by employer self-insured plans" so that "for the roughly 50% of the privately insureds in Arkansas who are covered by employer self-insurance programs," the plaintiffs "remain out of network." This last phrase is key: as to plans that are preempted by ERISA, the plaintiffs "remain out of network." Similarly, paragraph 62 alleges that the plaintiffs were excluded from the network in 1997, and "the defendants have never permitted the plaintiffs back into the FirstSource network." The action taken by the defendants in early 2006 was not a new and independent act that inflicted new and accumulating injury on the plaintiffs. As to those persons covered by employer self-insured plans, the plaintiffs' situation now is the same as it was in 1997 when they were first excluded from the managed care network as a whole. The action of the defendants in early 2006, allowing the plaintiffs into the network to the extent that the any willing provider statute could be enforced, helped the defendants; it did not

injure them. The decision continuing their exclusion from the network for employer self-insured programs was merely a reaffirmation of the decision in 1997 to exclude them from the network as to those programs.

The plaintiffs have also argued that Blue Cross's refusal to reimburse the cath lab opened by Little Rock Cardiology Clinic in 2003 is another new and independent act that inflicted new and accumulating injury on the plaintiffs. Little Rock Cardiology Clinic had been excluded from the Blue Cross networks for six years by the time that the cath lab was opened. According to the third amended complaint, during that time, Little Rock Cardiology Clinic, its doctors, and their patients made numerous requests to be re-admitted into the network, but Blue Cross and HMO Partners "refused to budge from the exclusion." Third Am. Compl., P 141. During that time, whenever a physician left Little Rock Cardiology Clinic, that doctor was "immediately reinstated to in-network status in both the PPO and the HMO." Third Am. Compl., P 142. Conversely, whenever a doctor joined Little Rock Cardiology Clinic, that doctor was excluded from the network. Third Am. Compl., P 143. Nothing in the third amended complaint offers any reason to believe that Blue Cross's refusal to reimburse Little Rock Cardiology Clinic's cath lab was anything other than the unabated inertial consequence of the 1997 decision not to do business with Little Rock Cardiology Clinic.

"Most courts see no continuing violation when the initial refusal to deal is 'irrevocable, immutable, permanent and final.'" II PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW P 320c, at 294 (3d ed. 2007) (quoting *Multidistrict Ve-*

hicle Air Pollution v. General Motors Corp., 591 F.2d 68, 72 (9th Cir.), cert. denied, 444 U.S. 900, 100 S. Ct. 210, 62 L. Ed. 2d 136 (1979)). If ever a refusal to deal was "irrevocable, immutable, permanent, and final," this one was. Throughout every change in the marketplace, Blue Cross has adhered to the policy adopted in 1997 that, to the extent permitted by law, it would refuse to deal with Little Rock Cardiology Clinic and its doctors. "In such circumstances, implementation is only a reaffirmation of the policy's adoption, and the statute begins to run as soon as the competitor suffers injury." *Midwestern Mach., 392 F.3d at 270.*

Although not alleged in the third amended complaint, the plaintiffs also argue that Blue Cross committed an overt act in 2007. The alleged overt act in 2007 was taken in response to a suit filed in state court by Little Rock Cardiology Clinic and others against Blue Cross to recover damages sustained while enforcement of the any willing provider statute was enjoined. In response to the action for damages filed in state court, Blue Cross filed an action in this Court seeking to enjoin pursuit of the state-court action. Blue Cross argued that the state-court action for damages was inconsistent with the injunction, and, therefore, this Court should enjoin pursuit of the state-court action. This Court dismissed the complaint for lack of subject matter jurisdiction. *See Ark. Blue Cross & Blue Shield v. St. Vincent Infirmary Med. Ctr., No. 4:07CV813, 2007 U.S. Dist. LEXIS 92101, 2007 WL 4287842 (E.D. Ark. Dec. 5, 2007).* The action filed in this Court in 2007 did not seek to exclude the plaintiffs from competing in the market, however defined, and was not a new and independent act in furtherance of an antitrust viola-

tion that inflicted new and accumulating injury to the plaintiffs. *Midwestern Mach., 392 F.2d at 271.* It was a defensive move -- a response to a complaint for damages -- raising in this Court a good faith defense that also could be and presumably was raised in state court after this Court dismissed for lack of jurisdiction.

As to Arkansas Blue Cross and Blue Shield, US-Able Corporation, Baptist Medical System HMO, Inc., and HMO Partners, Inc., the plaintiffs' claims are barred because the third amended complaint alleges no acts occurring within four years of the filing of the second amended complaint on December 17, 2007, other than the unabated inertial consequences of the decision in 1997 not to deal with Little Rock Cardiology Clinic and its physicians. As to those four defendants, all of the plaintiffs' claims are barred by the statute of limitations.

B. WHETHER PLAINTIFFS' CLAIMS AGAINST BAPTIST HEALTH ARE BARRED BY LIMITATIONS

As mentioned, Baptist Health was named as a defendant in the original complaint, which was filed on November 2, 2006. Baptist Health adopted its economic credentialing policy in 2003, which was less than four years before that complaint was filed. The adoption of the economic credentialing policy can fairly be regarded as an overt act in furtherance of the alleged monopolization of a market for hospital services for cardiology patients and cannot fairly be regarded as the unabated inertial consequences of previous acts. Baptist Health has argued that the plaintiffs have not been injured by the economic cre-

dentialing policy because enforcement of it was preliminarily enjoined in 2004, but the third amended complaint sufficiently alleges that the plaintiffs were injured by the enactment of the policy. Therefore, the claims in Counts I-IV are not barred by limitations as to Baptist Health.

The third amended complaint alleges in Count V that Baptist Health was part of the conspiracy to monopolize the private insurance market and in Count VI that it was part of the attempt to monopolize that market. [6] The plaintiffs argue that Baptist Health's adoption of the economic credentialing policy in May 2003 is an overt act in furtherance of the conspiracy to monopolize the private insurance market. As noted, that act occurred less than four years before the initial complaint was filed in this case, so, if it could fairly be regarded as an act in furtherance of the conspiracy to monopolize the private insurance market, the claims against Baptist Health alleging conspiracy and attempt to monopolize the private insurance market would not be barred by limitations, assuming that the claims in Counts V and VI relate back to the original complaint.

6 As noted above, Baptist Health is not named in Count VII.

The factual allegations regarding the economic credentialing policy appear in paragraphs 146 through 154 of the third amended complaint. Paragraph 146 alleges that in late 2002 Baptist Health learned that neurosurgeons and orthopedists on staff at Baptist Health planned to form a specialty hospital, which Baptist Health called the "spine hospital," and that the economic credentialing policy resulted

from efforts to protect Baptist Health from the spine hospital. According to paragraph 147, the purpose of the economic credentialing policy was to stifle competition from competing hospitals. That paragraph states, in part, "the President of Baptist Health has admitted under oath that the primary purpose, and the only purpose he could think of, for the policy was to discourage specialty hospitals from entering the marketplace and to exclude them from it." Assuming these allegations to be true, the purpose of the economic credentialing policy was to stifle competition in the market for hospital services, not to stifle competition in the market for private insurance.

Paragraph 149 alleges that minutes of a meeting of the executive committee of Baptist Health show that there was to be "reconfirmation with Blue Cross regarding no access to network;" meaning the network from which the plaintiffs were excluded in 1997. Thus, the involvement of Blue Cross was to confirm the status quo. No other involvement by Blue Cross in Baptist Health's economic credentialing policy is alleged. No allegation is made that Blue Cross requested that Baptist Health adopt that policy, nor that Baptist Health intended, when it adopted the policy, to benefit Blue Cross. Indeed, as noted, the specific factual allegation is that the purpose of the policy was to prevent specialty hospitals from competing with Baptist Health, not that its purpose was to assist Blue Cross. The third amended complaint does not allege that Blue Cross acted in 2003 to exclude from the network any physicians who had not already been excluded; and, as noted above, according to the third amended complaint, the cardiologists at Little Rock Cardiology Clinic are the only specialists in the state who have been excluded.

So far as the private insurance market is concerned, Baptist Health's economic credentialing policy changed nothing.

Although paragraph 223 alleges in conclusory fashion that adoption of the economic credentialing policy by Baptist Health in 2003 was an overt act in furtherance of the conspiracy to monopolize the private insurance market, the Court is not required to accept that conclusion. *See Twombly, 127 S. Ct. at 1965*; *Stalley, 509 F.3d at 521*; *Wiles, 280 F.3d at 870*. The detailed factual pleadings in paragraphs 146 through 154 -- which the Court must and does accept as true -- belie the conclusion in paragraph 223 that the economic credentialing policy was an overt act in furtherance of a conspiracy or an attempt to monopolize the market for private insurance. It is true that plaintiffs' theory of the case is that Baptist Health and Blue Cross conspired each to aid the other in building two reciprocally reinforcing monopolies; but, even if that is true, Baptist Health's economic credentialing policy was, according to the third amended complaint, an action taken by Baptist Health to protect Baptist Health from competition from specialty hospitals, not an action taken by Baptist Health to protect Blue Cross from competition in the private insurance market. Any connection between that policy and the private insurance market is too attenuated for the adoption of that policy to be deemed a continuing violation of the antitrust laws in the private insurance market. The third amended complaint, therefore, alleges no overt act in furtherance of the conspiracy or attempt to monopolize the private insurance market within four years of the date that the plaintiffs filed their initial complaint in this action. The claims asserted against Baptist

Health in Counts V and VI are barred by the statute of limitations.

As noted above, the claims against Baptist Health in Counts I-IV are not barred by the statute of limitations, so the Court must address the substance of those counts to rule on the motion to dismiss as to them.

III. THE RELEVANT MARKET FOR COUNTS I-IV

Because no per se violation of *section 1* is alleged, it is necessary for the plaintiffs to allege a valid relevant market on the *section 1* claim as well as on the *section 2* claims. *Double D Spotting Serv., Inc. v. Supervalu, Inc., 136 F.3d 554, 560 (8th Cir. 1998).*

> If an antitrust complaint requires proof of a relevant market the plaintiff must allege such a market in its complaint, including the geographic market. In addition, the pleading must be comprehensible, sufficiently particular to put the defendant on notice of the alleged market's boundaries, and plausible, or perhaps merely "conceivable."

IIB PHILLIP E. AREEDA, HERBERT HOVENKAMP & JOHN L. SOLOW, ANTITRUST LAW P 531f (3d ed. 2007) (footnotes omitted). Although courts should be hesitant to dismiss antitrust actions before discovery, and although the definition of the relevant market requires a factual inquiry into the commercial realities faced by consumers, there is no prohibi-

tion against dismissing an antitrust claim pursuant to *Rule 12(b)(6)* for failure to plead a relevant market. *Queen City Pizza, Inc. v. Domino's Pizza, Inc., 124 F.3d 430, 436 (3d Cir. 1997).* "[C]ourts have not hesitated to dismiss antitrust claims where it is clear that the alleged relevant market is too narrow, implausible, defined solely by franchise agreement, or simply not defined anywhere in the pleadings." *Ferguson Med. Group, L.P. v. Missouri Delta Med. Ctr., No. 1:06CV8, 2006 U.S. Dist. LEXIS 53493, 2006 WL 2225454, at *3 (E.D. Mo. Aug. 2, 2006).*

A relevant product market has two components -- a product market and a geographic market. *Bathke v. Casey's Gen. Stores, Inc., 64 F.3d 340, 345 (8th Cir. 1995)).* We turn first to the relevant product market.

A. THE PRODUCT MARKET

The third amended complaint alleges:

> 22. The relevant product is those medical services that cardiology patients receive exclusively in a hospital from a cardiologist. These include all interventions involving the heart and the more complex interventions involving peripheral arteries and organs.
>
> 23. That patients obtain cardiology services only in conjunction with associated hospital services means that the relevant cardiology services and hospital services are not distinct products for purposes of antitrust analysis. *See Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S.*

2, 43, 104 S. Ct. 1551, 80 L. Ed. 2d 2 (1984) (O'Connor, J., concurring).

The third amended complaint also alleges that there are two separate health insurance markets, one for government programs, most significantly Medicare and Medicaid, and one for private insurance. The third amended complaint further alleges:

> 35. This case involves the private insurance market, the hospital services market, and the cardiology services market. The first relevant product market at issue in this lawsuit (a market to be examined for competitive injury) is the market for cardiology procedures obtained in hospitals by patients covered by private insurance. In general, this product market includes all interventions involving the heart and the more complex peripheral interventions.
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> 36. The second relevant product market at issue in this lawsuit (also to be examined by competitive injury) is the market for private health insurance. This market includes group health insurance plans, individual health insurance plans and employer self-insured health plans.
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> 38. The hospital services market in general (as opposed to for cardiology procedures) is also a subject of inquiry in this lawsuit, but plaintiffs do not assert distinct injury in this market. This general

> hospital services market is a source of defendants' market power that has been used for anticompetitive purpose and effect.

Count I alleges that the defendants have engaged in "anticompetitive conduct for the purpose of restraining commerce in the market for hospital services for cardiology patients covered by private insurance." Count II is entitled "Conspiracy to Monopolize - Cardiology Procedures" and alleges that the defendants "have combined and conspired to monopolize the market for hospital services for privately insured cardiology patients . . . ." Similarly, Count III is entitled "Attempt to Monopolize - Cardiology Procedures" and alleges, "defendants have attempted to monopolize the market for hospital services for privately insured cardiology patients . . . ." Likewise, Count IV is entitled "Monopolization -- Cardiology Procedures" and alleges, "Baptist Health has and continues to possess monopoly power in the market for hospital services for privately insured cardiology patients."

1. Assuming That The Relevant Product Market Is Defined in Terms of Cardiologist's Services, Counts I-IV of The Third Amended Complaint Must Be Dismissed.

We have quoted at length from the third amended complaint because the first difficulty is determining what the plaintiffs intend to allege as the product market for Counts I-IV. Because the plaintiffs are cardiologists, one might expect that the product

market would be services offered by cardiologists, and some paragraphs in the third amended complaint appear so to state. Paragraph 22, for example, defines the relevant product market as medical services that cardiology patients receive in a hospital from a cardiologist.

If that is the product market -- services offered by cardiologists to hospitalized patients -- then the *section 2* claims asserted in Counts II, III, and IV necessarily fail. No defendant offers the services that cardiologists offer, which is to say that no defendant competes in the market for cardiology services. "Monopoly exists when one firm controls all or the bulk of a product's output and no other firm can enter the market, or expand output, at comparable costs." IIB ANTITRUST LAW P 403a (footnote omitted). More simply, a monopoly is a market condition in which "only one economic entity produces a particular product or provides a particular service" or the market condition approaches that level of concentration. BLACK'S LAW DICTIONARY 1028 (8th ed. 2004). No one can monopolize a market if he does not produce the product or deliver the services constituting that market, which is to say that no one can monopolize a market in which he does not compete. No one can attempt to monopolize a market without attempting to compete in that market. No one can conspire to monopolize a market unless at least one of the coconspirators competes in that market. No defendant in this case offers the services that cardiologists offer, so no defendant in this case competes in the market of services offered by cardiologists. Even if the market is limited to services provided by cardiologists in a hospital, and even if it is limited to services provided by cardiologists in a hospital to pa-

tients who are privately insured, nevertheless, no defendant competes or is alleged to compete in that market. No defendant has market power in that market. *Cf. Gordon v. Lewistown Hosp., 272 F. Supp. 2d 393, 421 n.24 (M.D. Pa. 2003)* ("The [h]ospital . . . is not a participant in the physician services aspects of these markets and, therefore, cannot possess market power in those markets."). Thus, as a matter of law, Counts II, III, and IV fail to state a claim for relief if the relevant product market consists of services offered by cardiologists.

The *section 1* claim also must be dismissed if the relevant product market consists of services offered by cardiologists. If a defendant has no market power in the relevant market, the plaintiff must allege adverse effects on competition in the relevant market, which in this instance would mean an adverse effect on competition among cardiologists, such as increased prices for services offered by cardiologists or a decline in either the quality or quantity of services offered by cardiologists. *Minn. Ass'n of Nurse Anesthetists v. Unity Hosp., 208 F.3d 655, 662 (8th Cir. 2000); Flegel v. Christian Hosp., Northeast-Northwest, 4 F.3d 682, 688-89 (8th Cir. 1993).* If the product market is limited to medical services offered by cardiologists in a hospital to patients who are privately insured, the plaintiffs would need to allege adverse effects on competition in that market, such as increased prices for services by cardiologists to privately insured patients in hospitals, or a decline in either the quality or quantity of services by cardiologists to privately insured patients in hospitals. *Minn. Ass'n of Nurse Anesthetists, 208 F.3d at 662.* However, the third amended complaint makes no such allegations.

The third amended complaint touches on the issue of competition among cardiologists only in paragraphs 49 and 50, which are in the section of the third amended complaint describing the alleged geographic market, not in the section describing the alleged product market. Paragraphs 49 and 50 allege:

> 49. Little Rock is also where Arkansas's cardiologists are located. According to information from the Arkansas Medical Board, there are 138 cardiologists in the entire state of Arkansas, and 51 of them reside in the Central Public Health Region cities of Conway, Hot Springs, Little Rock, North Little Rock, and Pine Bluff. Of these 51, 41 are in Little Rock and North Little Rock. This is 80% of the total from the Region, and 29% of the statewide total. As between Little Rock and North Little Rock, 33 cardiologists are in Little Rock and 8 are in North Little Rock. The reason why cardiologists reside in the Little Rock market in these numbers is that it is the largest market for cardiology services in the state, retaining the overwhelming majority of Little Rock patients who seek cardiology services and drawing large numbers of patients from around the state for medical procedures that require hospital services.
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> 50. In addition, a larger percentage of the cardiologists who perform in-hospital procedures known as interventional cardiology, including the plaintiffs, are located

in Little Rock rather than outside of Little Rock.

Nowhere does the third amended complaint allege that the anticompetitive conduct of the defendants has resulted in cardiologists raising their prices for privately insured patients in hospitals or, for that matter, any other patients. Nowhere does the third amended complaint allege that the anticompetitive conduct of the defendants has caused a decline in the number of cardiologists or in the quality of the services offered by cardiologists. Because the third amended complaint is silent as to the impact on competition among cardiologists, as distinct from the impact on the plaintiffs, and because no defendant has market power in the market for services offered by cardiologists, if the product market consists of services offered by cardiologists, Count I, which alleges a restraint of trade in violation of *section 1* of the Sherman Act, like Counts II, III, and IV, fails to state a claim for relief and therefore must be dismissed. *Dunn & Mavis, Inc. v. Nu-Car Driveaway, Inc., 691 F.2d 241, 245 (6th Cir. 1982)* ("Since the complaint does not allege facts suggesting that Chrysler's refusal to deal had any significant anticompetitive effect on the market, there is no rule of reason case alleged.").

2. Assuming That The Plaintiffs Intend to Allege That The Product Market Includes Both Cardiologists' Services and Hospital Services, Counts I-IV of The Third Amended Complaint Must Be Dismissed.

The third amended complaint contains extensive allegations of harmful effects on competition among hospitals that admit cardiology patients. The summary of these allegations is that the Arkansas Heart Hospital provides better quality services while charging lower prices than the Baptist Hospital in Little Rock. *See* Third Am. Compl., PP 166-173.

The observation that the third amended complaint alleges adverse effects on competition among hospitals that admit cardiology patients brings us to an alternative way of construing the third amended complaint's allegations regarding the relevant product market. Although paragraph 22 alleges that the relevant product market consists of medical services provided by cardiologists to patients in hospitals, the next paragraph alleges that, because patients obtain these cardiology services only in conjunction with associated hospital services, "the relevant cardiology services and the hospital services are not distinct products for purposes of antitrust analysis." Paragraph 35 alleges that the case involves the private insurance market, the hospital services market, and the cardiology services market, and, "[t]he first relevant product market at issue in this lawsuit (a market to be examined for competitive injury) is the market for cardiology procedures obtained in hospitals by patients covered by private insurance." This sentence, consistently with paragraph 23, appears to conflate the market for services offered by cardiologists to hospitalized patients with the market for services offered by hospitals to cardiology patients, so that the alleged product market is a single "market for cardiology procedures obtained in hospitals by patients covered by private insurance." Counts I-IV of the third amended complaint describe the market

as "the market for hospital services for cardiology patients covered by private insurance" or "the market for hospital services for privately insured cardiology patients" without distinguishing between a market for services offered by cardiologists to hospitalized patients and a market for services offered by hospitals to cardiology patients. Viewing all of these allegations together, it appears that the key to understanding the plaintiffs' theory as to the relevant product market is the assertion in paragraph 23 of the third amended complaint that cardiology services and hospital services "are not distinct products for purposes of antitrust analysis" for cardiology patients who require hospitalization. The plaintiffs likewise argue in their brief in response to the motions to dismiss that, because a cardiology patient in the relevant market must have both a hospital and a cardiologist, the services offered by a hospital and the services offered by a cardiologist to such a patient comprise a single product for purposes of antitrust analysis.

Thus, it appears that the plaintiffs intend to allege that the services offered by a hospital and the services offered by a cardiologist to hospitalized cardiology patients constitute one product for purposes of antitrust analysis; and they justify treating the services of the hospital and the services of the cardiologist as one product on the basis that a hospitalized cardiology patient needs both a hospital and a cardiologist. That a hospitalized cardiology patient needs both a hospital and a cardiologist is undoubtedly true; the legal conclusion that therefore the services offered by hospitals and the services offered by cardiologists to hospitalized cardiology patients are

in the same product market is false. The leading treatise on antitrust law explains:

> Substitutes are goods that can replace one another and thus "compete" for the user's purchase. For example, Chevrolets are substitutes for Fords, and coal in many uses is a substitute for natural gas. By contrast, complements are goods that are most efficiently made or used together. For example, gasoline and automobiles are complements, as are computer hardware and software, toasters and bread, or beef and leather. If two goods are produced most efficiently when they are made together, such as beef and leather, or lumber and sawdust, we speak of "complements in production." If two goods are consumed most efficiently when used together, such as bread and toasters or hardware and software, we speak of complements in demand," or "complements in consumption."
>
> When two goods are in the same relevant market -- that is, substitutes rather than complements -- a price increase in one typically occasions a price increase in the other. For example, if coal and natural gas are in the same market, a reduction in coal output will increase the demand for natural gas, thus causing its price to increase, as well as the coal price. Indeed, the entire concept of a "market" includes the notion that the prices of the goods in

the market tend to be uniform, or to rise and fall together.

In contrast, when goods are complements in demand, their prices tend to move in opposite directions. For example, gasoline and automobiles are complements, because a driver needs both. A significant output reduction and price increase in gasoline will cause less driving, which will reduce the demand for cars, causing a price decrease there.

Importantly, when the goods at issue are complements, the presence of market power in one says virtually nothing about the presence of market power in the other, even if a firm makes both. For example, a firm could be a monopoly producer of both cars and gasoline, a competitive producer of both, or a monopoly producer of one and a competitive producer of the other. A firm might have a monopoly in software, such as the Windows operating system, while computers, which are the complementary product that make Windows valuable, are sold in a highly competitive market.

It should be clear that a relevant market consists only of goods that are reasonably close *substitutes* for one another. Economists have understood markets this way for more than a century. The Supreme Court has indicated that relevant markets are composed of substitutes by defining market boundaries in terms of cross-elasticity of demand. That term

speaks of the rate at which people will substitute one item in response to a price increase in a different item -- a comparison that applies only to a relationship of substitution.

* * *

Grouping complementary goods into the same market is not only economic nonsense, it also undermines the rationale for the policy against monopolization or collusion in the first place. One "monopolizes" a market by reducing output, and once certain output is removed from the market, the remaining output experiences increase demand and a rise in prices. Thus a monopolist might monopolize the market for gasoline by reducing output from the competitive level of, say, 1,000,000 barrels, to a monopoly level of 700,000, with the result that demand intensifies for that which remains and the market clearing price rises. No such result obtains when one aggregates complementary goods into the same market. For example, grouping gasoline and tires in a "market" suggests that an output decrease in gasoline would permit an increase in tire prices. In fact, it will do just the opposite.

In grouping non substitutable and complementary parts into a single relevant market, the Ninth Circuit invoked the "commercial reality" that a service provider needed access to all the parties in

> order to provide service for Kodak photocopiers, and that the only inventory of "all parts" was Kodak's warehouse. But many "commercial realities" describe a particular market situation, and their invocation should not become an after-the-fact rationalization for a conclusion that is completely inconsistent with the economic rationale for defining markets. It is also a commercial realty that one must have both a toaster and bread to make toast, or both gasoline and an automobile to drive.
>
> In sum, a "commercial reality" provides evidence of a single relevant market if it tends to show the economic conditions meeting the criteria for a relevant market -- namely, that items in the proposed market are substitutes for one another, that customers can respond to a price increase in one by using the other instead, that suppliers can respond to price increases in one item by switching to producing it rather than the other, or that firms have to compete with one another to make the sale.

IIB ANTITRUST LAW P 565a (footnotes omitted); *see also Abraham v. Intermountain Health Care, Inc., 461 F.3d 1249, 1264 (10th Cir. 2006)*; *United States v. Microsoft Corp., 346 U.S. App. D.C. 330, 253 F.3d 34, 86 (D.C. Cir. 2001)*.

The plaintiffs attempt to avoid the conclusion that their services and those of Baptist Health are in

separate markets by asserting that the question is one of fact, not of law, but that assertion is wrong. Assuming as true the well-pleaded and irreproachable allegation that hospitalized cardiology patients require services from both a cardiologist and a hospital, what follows is not that both sets of services are in the same product market but rather the opposite -- the two sets of services are complements, not substitutes, and therefore are not in the same product market. This is not a factual question, but a legal one: does the law provide that, because a hospitalized cardiology patient requires both a cardiologist and a hospital, the services of the cardiologist and the services of the hospital are in the same product market? The answer is no.

The plaintiffs cite Justice O'Connor's concurring opinion in *Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 43, 104 S. Ct. 1551, 1574, 80 L. Ed. 2d 2 (1984)* (O'Connor, J., concurring), for the proposition that, because hospitalized cardiology patients require both a cardiologist and a hospital, the two services are not distinct products for antitrust purposes. Justice O'Connor's concurring opinion did say that there was no sound economic reason for treating surgery and anesthesia as separate services. *Id. at 43, 104 S. Ct. at 1574*. However, the opinion of the Court said, "the hospital's requirement that its patients obtain necessary anesthesiological services from Roux combined the purchase of two distinguishable services in a single transaction." *Id. at 24, 104 S. Ct. at 1564-65* (majority opinion); *see also Konik v. Champlain Valley Physicians Hosp. Med. Ctr., 733 F.2d 1007, 1017 (2nd Cir. 1984)* ("In light of the Supreme Court's recent ruling in *Hyde,* there seems to be little question that the Hospital's operating room facilities

and the provision of anesthesiology service must be viewed as separate services.") In *Hyde,* the hospital sold its services and those of anesthesiologists in a single transaction, and, when that arrangement was challenged as an illegal tie, the district court, the court of appeals, and the Supreme Court all held that anesthesiological services and hospital services were separate services. The reason was that "consumers differentiate between anesthesiological services and other hospital services . . . ." *Hyde, 466 U.S. at 23, 104 S. Ct. at 1564.* Here, no allegation is made that any hospital sells its services and those of cardiologists in a single transaction and no allegation is made that consumers fail to differentiate between them. The behavior of buyers and sellers as alleged in the third amended complaint is inconsistent with the argument that services offered by cardiologists to hospitalized patients are services offered by hospitals to cardiology patients as one product. [7]

> 7 The plaintiffs' argument on this point is also inconsistent with their (so far successful) argument in state court that Baptist Health's economic credentialing policy constitutes tortious interference with the doctor-patient relationship. *See Baptist Health v. Murphy, 365 Ark. at 123-25, 226 S.W.3d at 807-08.*

Finally, as support for their argument that the services offered by a hospital to cardiology patients and the services offered by a cardiologist to hospitalized patients should be regarded as a single product for antitrust purposes, the plaintiffs cited at oral argument the following paragraph from the Areeda treatise:

Often the "clustering" problem goes away with more careful attention to the precise input that is being monopolized. Consider a relevant market for "surgical services." Clearly, a heart bypass is not a substitute for an appendectomy, and neither one is a substitute for the surgical repair of a gunshot wound. But the problem of clustering non substitutes vanishes when we realize that any source of monopoly power lies in the *facility,* in this case the hospital's operating room and supporting equipment. Thus, for example, a local telephone company may have monopoly power over its telephone network, which we can describe as a relevant market, notwithstanding that the various services dependent on the network, which include voice conversations, fax transmissions, and Internet access, may not be good substitutes for each other. While in *Grinnell* the Supreme Court considered itself to be clustering noncompetitive products, such as fire and burglary alarm protection, the then-existing technology of the central station alarm protection industry indicates that the adopted grouping was not "clustering" at all, but the simple provision of remote protective services and alarm connections through a single telephone line, with a single operator monitoring the various alarms.

IIB ANTITRUST LAW P 565c. The plaintiffs construe this paragraph to say services offered by a surgeon and services offered by a hospital may be "clustered" for purposes of defining a relevant market, but that is not what the paragraph says. What the paragraph says is that, even though an appendectomy is not a substitute for surgical repair of a gunshot wound, when the hospital offers its services for an appendectomy and for repair of a gunshot wound, it is not offering two services but only one: a facility for surgery -- an operating room and supporting equipment. This paragraph does not say that the hospital's services and those of the surgeon can be clustered for purposes of defining a product market. This paragraph is part of a section of the treatise devoted to explaining the principle, "Most fundamentally, goods cannot be clustered unless there is a sufficient basis for inferring that the defendant has the required degree of market power over each of the goods in the cluster." *Id.* Here, as has been noted, Baptist Health does not compete in the cardiologists' services market; it has no market share and therefore no market power in the market for cardiologists' services. Therefore, the relevant product market cannot include both the services offered by hospitals and the services offered by cardiologists.

In summary, if the plaintiffs intend to allege that the relevant product market consists of services offered by cardiologists to privately insured hospitalized patients, Counts I-IV of the third amended complaint fail to state a claim upon which relief can be granted because no defendant competes in that market and the third amended complaint contains no allegations of an adverse effect on competition in that market; and, if the plaintiffs intend to allege that,

because hospitalized cardiology patients need both a hospital and a cardiologist the services of both must be treated as one for purposes of determining the relevant product, Counts I-IV of the third amended complaint must be dismissed for failure to state a claim because, as a matter of law, complementary products sold separately are not in the same product market.

3. The Relevant Product Market for Counts I-IV Cannot Be Defined by Reference to Whether The Patients Who Receive Services Are Privately Insured.

As the defendants have noted, the allegations regarding the relevant product market for Counts I-IV of the third amended complaint have yet another difficulty, and on this one there is no doubt as to what the plaintiffs intend to allege: the plaintiffs intend to restrict the relevant product market to services offered to patients who have private insurance. In other words, Counts I-IV of the third amended complaint exclude from the relevant product market services offered to hospitalized cardiology patients covered by Medicare or Medicaid, and they also exclude from the relevant product market services offered to cardiology patients who have no insurance. Thus, the plaintiffs propose to define the product market, in part, by how different customers pay for the services -- which is not the way that the product market is defined.

The argument that the product market can be defined in part by reference to whether purchasers pay with private insurance, through a government program, or otherwise, is a novel argument for which

there is little or no precedent, but, even without precedent, the Court has no doubt that defining the product market in this manner is inconsistent with the basic notion of a product market. How a purchaser pays for a product is irrelevant to the question of what the product is or whether the purchaser would consider that item or service interchangeable with another. As a standard jury instruction explains it, "in determining the product market, the basic idea is that the products within it are interchangeable as a practical matter from the buyer's point of view." 3A KEVIN F. O'MALLEY, JAY E. GRENIG & WILLIAM C. LEE, FEDERAL JURY PRACTICE & INSTRUCTIONS: CIVIL § 150.66 (5th ed. 2001). From the buyer's point of view, there may be an issue as to whether the services offered by one physician are interchangeable with the services of another or whether the services offered by one hospital are interchangeable with those of another, but how the buyer pays for the services is not relevant to the question of which services are interchangeable with one another.

During oral argument, when asked for the best authority for the proposition that the product market can be limited in terms of how consumers pay for the services, counsel for the plaintiffs cited *Reazin v. Blue Cross & Blue Shield of Kansas, Inc., 899 F.2d 951 (10th Cir. 1990).* In *Reazin,* the product market was "private health care financing." *Id. at 959* & n. 10. *Reazin* may be relevant to the plaintiffs' arguments that they have standing to sue for monopolization of the market for private health insurance as alleged in Counts V-VII of the third amended complaint, but it offers no support for the argument that the product market alleged in Counts I-IV -- the

market for services to hospitalized cardiology patients -- can be defined by reference to whether the patients pay for those services with private insurance.

The reason that the plaintiffs wish to define the product market as services to privately insured patients is that the wrongful act of which they complain and for which they seek equitable and monetary relief is their exclusion from the FirstSource network. The notion that the market for a service provider excluded from a healthcare network can be limited to consumers with private insurance was rejected in *Stop & Shop v. Blue Cross & Blue Shield of Rhode Island, 373 F.3d 57 (1st Cir. 2004)*, where the court held:

> Unfortunately for [plaintiffs' expert's] market definition, the concern in an ordinary exclusive dealing claim by a shut-out supplier is with the available market *for the supplier*. Here, for Walgreen and Stop & Shop, their potential customers are presumptively *all* retail customers for prescription drugs -- not just that smaller subgroup who are insured or reimbursed. To say that some sub-group of customers is foreclosed proves nothing by itself about the impact on pharmacies.

Id. at 67. Here, for the cardiologists at the Little Rock Cardiology Clinic who are excluded from the FirstSource network, their potential customers are all persons who need cardiologists' services, not just that smaller subgroup who are insured or reim-

bursed. To say that these cardiologists are foreclosed from the FirstSource network says nothing about the impact on competition among cardiologists. For each of the first four counts in the third amended complaint, a proper market definition would have to include all cardiology patients, or at least all hospitalized cardiology patients. *See also Brokerage Concepts, Inc. v. U.S. Healthcare, Inc., 140 F.3d 494, 513-14 (3d Cir. 1998).*

B. THE GEOGRAPHIC MARKET

The geographic market "includes the geographic area in which consumers can practically seek alternative sources of the product, and it can be defined as 'the market area in which the seller operates.'" *Double D Spotting Serv., 136 F.3d at 560* (quoting *Tampa Elec. Co. v. Nashville Coal Co., 365 U.S. 320, 327, 81 S. Ct. 623, 628, 5 L. Ed. 2d 580 (1961)).* "A geographic market is determined not by where consumers *actually* go for a particular product or service, but rather by where they *could* go should the defendants' prices become anticompetitive." *Ferguson Med. Group, 2006 U.S. Dist. LEXIS 53493, 2006 WL 2225454, at *2; see also Bathke, 64 F.3d at 345.* Although this is ordinarily a factual inquiry, courts have not hesitated to dismiss antitrust claims where it is clear that the alleged geographic market is too narrow or implausible. *Ferguson Med. Group, 2006 U.S. Dist. LEXIS 53493, 2006 WL 2225454, at *3.*

The third amended complaint defines the relevant geographic market as the cities of Little Rock and North Little Rock. On the face of it, it seems implausible that the geographic market for cardiologists who practice in Little Rock or North Little Rock

or for hospitals in Little Rock and North Little Rock would be limited to the city limits, and the parties have cited no comparable case in which the geographic market coincided with the city limits. 2 JOHN MILES, HEALTH CARE & ANTITRUST LAW § 12:11 (2008) ("Arbitrary geographical and political boundaries rarely should constitute relevant geographic markets for antitrust purposes because their establishment's [sic] usually based on factors other than competitive relationships among the hospitals in the area."). Moreover, the third amended complaint includes factual allegations that are inconsistent with the definition of the geographic market, and the method of defining the geographic market, as explained in the third amended complaint, is flawed as a matter of law.

Although the trade area for a business and the relevant geographic market in which it competes are not identical, it seems logical that the relevant geographic market will not be smaller and usually will be larger than the trade area because, by definition, the business is competing for customers throughout its trade area, so that area must be in the geographic market; and, in addition to the trade area, the geographic market must include places to which that business's customers could turn to obtain the product. *Cf. Bathke, 64 F.3d at 346.*

Paragraph 51 of the third amended complaint alleges that the hospitals in Little Rock serve not only 99.5% of residents in Little Rock, "but also a large percentage of residents from around the state who need cardiology services in hospitals." "Where substantial immigration occurs, the outlying area may need to be included in the relevant geographic mar-

ket even if outmigration is small." 2 HEALTH CARE & ANTITRUST LAW § 12:11. Paragraph 161 of the third amended complaint alleges that a cardiologist in El Dorado, which is 117 miles from Little Rock (nearly the same distance from Little Rock as is Memphis), referred patients to the Arkansas Heart Hospital because Baptist Health had no room for admitting more cardiology patients. Paragraph 43 of the third amended complaint alleges:

> The hospitals in surrounding areas that offer cardiology services, such as Conway Regional Medical Center and hospitals in Searcy, [8] are not equipped to receive significant numbers of cardiology patients from Little Rock, and some of the more sophisticated cardiology procedures are available only at Little Rock hospitals. For this reason, Little Rock hospitals attract patients in large numbers from outside of Little Rock for cardiology procedures, but Little Rock cardiology patients rarely go outside of the Little Rock market for these services.
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> 8 The use of the phrase "such as," indicates that there are surrounding cities other than Conway and Searcy in which hospitals that admit cardiology patients are located. In light of the allegations in paragraph 49, presumably these cities would include Pine Bluff and Hot Springs.

These allegations show, first, that the market area in which the seller operates is larger than simply the cities of Little Rock and North Little Rock

and, secondly, that there are competitors, such as the Conway Regional Medical Center and hospitals in Searcy, to which at least some cardiology patients who currently seek medical services in Little Rock or North Little Rock could turn. If the hospitals in those cities offer services to cardiology patients, it follows that there must be cardiologists also offering services there. Paragraph 49 of the third amended complaint indicates that ten cardiologists reside in Conway, Hot Springs, or Pine Bluff. Even if these hospitals and cardiologists could not receive significant numbers of cardiology patients from Little Rock and North Little Rock, that fact alone would not exclude them from the geographic market. The third amended complaint, itself, makes clear that some cardiology patients who could seek medical services in Little Rock or North Little Rock instead seek treatment in surrounding cities such as Conway and Searcy, and so, at a minimum, Conway and Searcy must be included in the geographic market even if very few cardiology patients who reside in Little Rock or North Little Rock currently seek treatment in Conway or Searcy.

Paragraph 45 alleges, in pertinent part, "of the privately insured cardiology patients who reside in Little Rock and its surrounding areas, which are the zip codes that begin with 722 and 721, 84.7% use hospitals in Little Rock. The remaining 15.3% of cardiology patients in these zip codes use hospitals in North Little Rock and Conway." Paragraph 46 then alleges:

> The area covered by the 722 and 721 three-digit zip codes is larger than the geographic market at issue, which is the

cities of Little Rock and North Little Rock. On information and belief, the percentage of cardiology patients in Little Rock and North Little Rock who use hospitals in Little Rock exceeds 85% and approaches 95%.

No reason appears for excluding from the geographic market the "surrounding areas" described in paragraph 45 where some of the residents use hospitals in Conway. Mayflower, for instance, has a 721 zip code and is between North Little Rock and Conway so that its residents could seek medical services in either city. Sherwood, which has four zip codes, all of which start with 721, is contiguous with North Little Rock. No reason appears for excluding Sherwood and Mayflower from the geographic market; and the same can be said of other surrounding areas. There is no apparent reason why Cabot, which is between North Little Rock and Searcy, would not be included in the relevant geographic market. Both common sense and the allegations in the complaint indicate that cardiology patients in these surrounding areas, such as Mayflower, Sherwood, and Cabot, can and do obtain services in Little Rock and North Little Rock. Accepting the allegations in the complaint as true, it also would seem that cardiology patients who live in Mayflower could turn to Conway for treatment, while cardiology patients who live in Cabot could turn to Searcy or Cabot for treatment. No reason appears for limiting the relevant geographic market to the city limits of Little Rock and North Little Rock other than to gerrymander the geographic market.

If the geographic market were not implausible on its face, little might be required in the complaint to survive a motion to dismiss, but where, as here, the geographic market alleged in the complaint appears implausible, more detailed pleading to justify the alleged geographic market may be required. *See* IIB ANTITRUST LAW P 531f, at 238-40.

The plaintiffs justify limiting the relevant geographic market to Little Rock and North Little Rock by alleging that as many as 95% of cardiology patients in Little Rock and North Little Rock seek cardiology services in Little Rock or North Little Rock. For purposes of ruling on the motion to dismiss, the Court must and does assume that that fact is true. Nevertheless, the fact that nearly every cardiology patient in Little Rock and North Little Rock currently seeks cardiology services in Little Rock or North Little Rock does not mean that Little Rock and North Little Rock may be defined as the relevant geographic market. This approach to defining the relevant geographic market was rejected by the Eighth Circuit in *Morgenstern v. Wilson, 29 F.3d 1291 (8th Cir. 1994).* In *Morgenstern,* a cardiac surgeon in Lincoln, Nebraska, prevailed at trial on his claim other surgeons in Lincoln had monopolized the market for cardiac surgery. On appeal, the Eighth Circuit reversed because the plaintiff's geographic market was, as a matter of law, too narrow, and because he could not show monopoly power in a properly drawn geographic market. In that case, the plaintiff presented expert testimony that the geographic market included 26 counties and extended some 200 miles from Lincoln but excluded Omaha "because patients overwhelmingly went to the closest hospital." *Id. at 1297.* The Eighth Circuit held that

that method of defining the geographic market was invalid as a matter of law because it did not address where patients could practically turn for alternatives. *Id. at 1296-97.* Likewise, in *Ferguson Medical Group,* the plaintiff proposed a geographic market that included areas from which 80-90% of its and the defendant's patients came, but the court held that the proposed geographic market was invalid as a matter of law because it was "based on where defendant's customers actually go for services, not where the customers could practically turn for services" and that "consumer preference, alone, is not a sufficient basis on which to determine a geographic market." *Ferguson Med. Group, 2006 U.S. Dist. LEXIS 53493, 2006 WL 2225454, at *4; see also Surgical Care Ctr. of Hammond, L.C. v. Hosp. Serv. Dist. No. 1, 309 F.3d 836, 840 (5th Cir. 2002); Minn. Ass'n of Nurse Anesthetists, 208 F.3d at 662; Federal Trade Comm'n v. Tenet, 186 F.3d 1045, 1052 (8th Cir. 1999).* If the plaintiffs' method of defining the geographic market were valid, antitrust plaintiffs could define a market by identifying any small area around the defendant's location in which nearly all potential customers patronize the defendant. If the geographic market could be defined in that manner, if everyone within a block of a hospital always seeks treatment at that hospital, the geographic market could be as small as one block, which is absurd.

In short, as to Counts I-IV, not only does the third amended complaint fail to allege a coherent product market, it also fails to allege a proper geographic market.

IV. COUNT VIII

Count VIII seeks an injunction "compelling the defendants to admit plaintiffs to their plans for self-insured employees and to reimburse the LRCC cath lab on the same terms as they reimburse hospitals that provide the same services." Third Am. Compl., P 247. Having dismissed Counts I-IV for failure to state a claim for relief, the Court cannot award injunctive relief on those claims, so the only issue is whether the Court should entertain plaintiffs' claims for injunctive relief for the antitrust violations in the market for private insurance alleged in Counts V-VII.

The period of limitations provided in *section 4B* of the Clayton Act does not apply to claims for equitable relief. II ANTITRUST LAW P 320g. However, antitrust claims for equitable relief are subject to the equitable doctrine of laches. *Id.* The doctrine of laches provides that an equitable claim is barred if the plaintiff is guilty of unreasonable and inexcusable delay that results in prejudice to the defendant. *Midwestern Mach., 392 F.3d at 277.* Some courts have said that the four-year statutory limitation period for damage actions should be used as a guideline in considering whether claims for equitable relief are barred. II ANTITRUST LAW P 320g, at 326; *IT&T Corp. v. General Tel. & Elec. Corp., 518 F.2d 913, 928 (9th Cir. 1975), overruled on other grounds, California v. American Stores Co., 495 U.S. 271, 110 S. Ct. 1853, 109 L. Ed. 2d 240 (1990)*; *see also Aurora Enters., Inc. v. Nat'l Broad. Co., Inc., 688 F.2d 689, 694 (9th Cir. 1982)* ("If the district court had explicitly applied that guideline, it would have correctly dismissed a request for injunctive relief on the ground of laches."); *Kaiser Aluminum & Chem. Sales, Inc. v. Avondale Shipyards, Inc., 677 F.2d*

1045, 1057 (5th Cir. 1982). However, "the operation of laches departs from that of statutes of limitations in that laches is more flexible." *Goodman v. McDonnell Douglas Corp., 606 F.2d 800, 805 (8th Cir. 1979)*. The application of laches requires the court "to examine all aspects of the equities affecting each case." *Id. at 806*. In the Eighth Circuit, the "statute of limitation is a rough rule of thumb in considering the question of laches, and constitutes a pertinent factor in evaluating the equities." *Reynolds v. Heartland Transp., 849 F.2d 1074, 1075-76 (8th Cir. 1988)*; *see also Midwestern Mach., 392 F.2d at 277*. In *Reynolds,* the court affirmed application of laches based on unreasonable delay by the plaintiff without discussing whether the delay had caused prejudice to the defendant.

According to the third amended complaint, the conspiracy to monopolize the private insurance market began no later than 1997, the alleged injury to the plaintiffs occurred when the plaintiffs were excluded from the defendants' managed care network in 1997, and Blue Cross had achieved a monopoly in that market by 2001. Nevertheless, the plaintiffs did not allege their claims regarding the private insurance market until March 27, 2008, when they filed the third amended complaint. The statute of limitations expired long before these claims were asserted. These plaintiffs waited almost eleven years after they were excluded from the network and almost seven years after the defendants allegedly had achieved monopoly power in the private insurance market before seeking relief. The wrongful conduct was not hidden. These plaintiffs knew immediately when they were excluded from the network. In view of the history of litigation between these parties, it

would be too much to say that they slept on their rights; but it is not too much to say that they slept on their rights to equitable relief under the Sherman and Clayton Acts.

The plaintiffs have offered no justification for their delay. None of the parties specifically addressed the issue of prejudice. The defendants have not cited any prejudice that the delay caused nor have the plaintiffs argued that the Court should not invoke the doctrine of laches inasmuch as the defendants have cited no prejudice to them. Here, the delay has been lengthy, and the statute of limitations has long since run. Had the plaintiffs offered some reasonable justification for the delay or argued that laches should not apply because the defendants have suffered no prejudice, the Court might hold that the equitable claims are not barred by laches; but in the absence of one or the other, in considering all of the equities, the Court has concluded that the balance weighs in favor of dismissing the equitable claims as barred by laches. Count VIII is therefore dismissed.

CONCLUSION

The Court has concluded, with some reluctance and perhaps belatedly, that the third amended complaint must be dismissed with prejudice. Nearly two years after the commencement of this action, "there continues to be no hint of a coherent and promising antitrust claim." *Eastern Food Servs., Inc. v. Pontifical Catholic Univ. Servs. Ass'n, Inc., 357 F.3d 1, 9 (1st Cir. 2004).* The plaintiffs may have one or more claims for intentional interference with contractual relationships or business expectancies; they may have claims for damages arising under the any will-

ing provider statute; and they may have other claims. But they have no viable antitrust claims. Their continued inability to plead a coherent relevant market has led the Court to the conclusion that, not only must Counts I-IV be dismissed, but also that they must be dismissed with prejudice. The third amended complaint also shows that Counts V, VI, and VII are barred by the statute of limitations. Except as to Baptist Health, the claims asserted in Counts I-IV also are barred by the statute of limitations. The claims for equitable relief are barred by laches. Therefore, the third amended complaint in its entirety is dismissed with prejudice.

IT IS SO ORDERED this 29th day of August, 2008.

/s/ J. Leon Holmes

J. LEON HOLMES

UNITED STATES DISTRICT JUDGE

SHERMAN ANTITRUST ACT, 15 U.S.C. § 1

§ 1. Trusts, etc., in restraint of trade illegal; penalty

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $ 100,000,000 if a corporation, or, if any other person, $ 1,000,000, or by imprisonment not exceeding 10 years, or by both said punishments, in the discretion of the court.

SHERMAN ANTITRUST ACT, 15 U.S.C. § 2

§ 2. Monopolization; penalty

Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $ 100,000,000 if a corporation, or, if any other person, $ 1,000,000, or by imprisonment not exceeding 10 years, or by both said punishments, in the discretion of the court.

SHERMAN ANTITRUST ACT, 15 U.S.C. § 15

§ 15. Suits by persons injured

(a) Amount of recovery; prejudgment interest. Except as provided in subsection (b), any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor in any district court of the United States in the district in which the defendant resides or is found or has an agent, without respect to the amount in controversy, and shall recover threefold the damages by him sustained, and the cost of suit, including a reasonable attorney's fee. The court may award under this section, pursuant to a motion by such person promptly made, simple interest on actual damages for the period beginning on the date of service of such person's pleading setting forth a claim under the antitrust laws and ending on the date of judgment, or for any shorter period therein, if the court finds that the award of such interest for such period is just in the circumstances. In determining whether an award of interest under this section for any period is just in the circumstances, the court shall consider only--

(1) whether such person or the opposing party, or either party's representative, made motions or asserted claims or defenses so lacking in merit as to show that such party or representative acted intentionally for delay, or otherwise acted in bad faith;

(2) whether, in the course of the action involved, such person or the opposing party, or either party's representative, violated any applicable rule, statute, or court order providing for sanctions for dilatory be-

havior or otherwise providing for expeditious proceedings; and

(3) whether such person or the opposing party, or either party's representative, engaged in conduct primarily for the purpose of delaying the litigation or increasing the cost thereof.

(b) Amount of damages payable to foreign states and instrumentalities of foreign states.

(1) Except as provided in paragraph (2), any person who is a foreign state may not recover under subsection (a) an amount in excess of the actual damages sustained by it and the cost of suit, including a reasonable attorney's fee.

(2) Paragraph (1) shall not apply to a foreign state if--

(A) such foreign state would be denied, under *section 1605(a)(2) of title 28 of the United States Code [28 USCS § 1605(a)(2)]*, immunity in a case in which the action is based upon a commercial activity, or an act, that is the subject matter of its claim under this section;

(B) such foreign state waives all defenses based upon or arising out of its status as a foreign state, to any claims brought against it in the same action;

(C) such foreign state engages primarily in commercial activities; and

(D) such foreign state does not function, with respect to the commercial activity, or the act, that is the subject matter of its claim under this section as a procurement entity for itself or for another foreign state.

(c) Definitions. For purposes of this section--

(1) the term "commercial activity" shall have the meaning given it in section 1603(d) of title 28, United States Code [*28 USCS § 1603(d)*], and

(2) the term "foreign state" shall have the meaning given it in section 1603(a) of title 28, United States Code [*28 USCS § 1603(a)*].

THE PETITIONERS' THIRD AMENDED COMPLAINT FILED IN THE UNITED STATES DISTRICT COURT EASTERN DISTRICT OF ARKANSAS ON MARCH 27, 2008

NO. 4-06-cv-1594-JLH

THIRD AMENDED COMPLAINT

Plaintiffs, for their complaint against defendants, state and allege:

1. This is an antitrust action under Sections 1 and 2 of the Sherman Act. Defendants Baptist Health and Blue Cross, directly and through their wholly owned subsidiaries and their jointly owned captive company, HMO Partners, have monopoly power in the markets for hospital services and private insurance for cardiology patients in Little Rock and North Little Rock.

2. Hospital services and health insurance are closely linked, critical and interdependent services for cardiology patients. Interventional cardiology heart procedures generally must take place in a hospital, using hospital services, and patients must have insurance, from either a government program such as Medicare or Medicaid, or from a private insurer, in order to pay for the hospital and physician services. For this reason, cardiology patients who must receive their treatment in a hospital require access to a hospital, a cardiologist, and a source of insurance.

3. These defendants have combined their hospital and insurance market positions in an exclusive dealing arrangement that creates

insurmountable barriers to entry in and the power to force exit from their service markets, including the market for cardiology patients, and this combination has prevented competition, resulting in higher prices for hospital services and insurance premiums, lower-quality hospital care and lack of patient choice. Potential health-insurance competitors of Blue Cross and HMO Partners are barred from entry because they cannot secure Baptist Health in an insurance network and therefore cannot offer a competitive insurance product. Other hospitals cannot enter or expand in the market because the defendants' exclusive-dealing arrangement denies them access to 80% of the insured patients in the geographic market, those enrolled in Blue Cross and HMO Partners plans, and this makes it impossible for other hospitals to compete for privately insured patients. As part of defendants' anticompetitive actions in their exclusive-dealing arrangement and exercise of monopoly power, defendants have excluded plaintiffs from Blue Cross and HMO Partners' insured patients, and they have attempted to exclude the plaintiffs from practicing at all at Baptist Health hospitals.

JURISDICTION AND VENUE

4. This Court has jurisdiction of plaintiffs' claims for relief under Section 4 of the Clayton Act (15 U.S.C. §15) as a result of defendants' violations of Sections 1 and 2 of the Sherman Act (15 U.S.C. §§1 and 2) as hereinafter alleged. Venue is proper under 28 U.S.C. §§1391(b) and (c) and 15 U.S.C. §§15 and 22 in that defendants reside and transact business

and are found in the judicial district of this Court, and the claims arose in this district.

THE PARTIES

5. Plaintiff Little Rock Cardiology Clinic, P.A., ("LRCC"), is a professional association of cardiologists located in Little Rock, Arkansas and has provided high quality cardiology specialty services since 1975.

6. Plaintiffs Dr. Bruce E. Murphy, and Bruce E. Murphy, M.D. P.A., Dr. Scott L. Beau and Scott L. Beau, M.D. P.A., Dr. David C. Bauman and David C. Bauman, M.D.P.A., Dr. D. Andrew Henry and D. Andrew Henry, M.D.P.A., Dr. David M. Mego and David M. Mego, M.D.P.A., Dr. Paulo Ribeiro and Paulo Ribeiro, M.D.P.A., Dr. William A. Rollefson and William A. Rollefson, M.D. P.A. are cardiologists and the professional corporations through which they practice at LRCC. Each individual plaintiff is a shareholder in LRCC.

7. Defendant Baptist Health is a non-profit corporation organized under the laws of Arkansas, with its principal place of business in Little Rock, Arkansas. It operates five hospitals in Arkansas, the largest being the 585-bed Baptist Health Center in Little Rock, and is the largest hospital company in Arkansas. Baptist Health is organized as a tax-exempt not-for-profit charitable organization.

8. Defendant Arkansas Blue Cross and Blue Shield, ("BCBS" or "Blue Cross"), is an Arkansas non-profit mutual insurance company with its principal place of business in Little Rock, Arkansas.

9. Defendant USAble Corporation ("USAble") is an Arkansas corporation, a wholly owned subsidiary of BCBS and a fifty percent owner of HMO Partners, Inc. Its board of directors, officers and actions are dominated by BCBS, and its actions are in reality and for purposes of the antitrust laws the actions of BCBS.

10. Defendant Baptist Medical System HMO, Inc. ("Baptist HMO") is an Arkansas corporation, a wholly owned subsidiary of Baptist Health, and a fifty percent owner of HMO Partners, Inc. Its board of directors, officers and actions are dominated by Baptist Health, and its actions are in reality and for purposes of the antitrust laws the actions of Baptist Health.

11. Defendant HMO Partners, Inc. ("HMO Partners") is an Arkansas corporation created by Baptist and BCBS, through their wholly owned subsidiaries, to pool the resources of Baptist and BCBS and to exercise their market power in insurance and hospital services. HMO Partners operates Health Advantage, the largest HMO in Little Rock, central Arkansas, and the State of Arkansas.

12. Baptist, directly and through Baptist HMO, and BCBS, directly and through USAble, and HMO Partners, have combined forces to monopolize hospital and private insurance for cardiology patients in the Little Rock market.

13. These defendants have combined and acted in concert unlawfully to exclude the plaintiffs from access to cardiology patients covered by BCBS and HMO Partners health plans and to attempt to exclude the plaintiffs and their patients from the

hospital facilities of Baptist Health, all in order to protect the defendants from competition.

THE RELEVANT MEDICAL PROCEDURES AND PRODUCT MARKETS

14. Cardiology procedures include procedures directly relating to the heart and its arteries, such as diagnostic procedures involving imaging or interventional procedures such as to clear blockages, or to install a pacemaker, and procedures that involve the entire arterial system of the human body, such as clearing blockages in arteries in the neck, brain, legs, kidneys and other organs, and diagnostic procedures relating to these arteries. Procedures that involve systems other than the heart are known as "peripheral procedures."

15. In general terms, "diagnostic procedures" are those that are intended to diagnose problems in the heart and arteries. Diagnostic procedures may involve invasive procedures such as catheterization or imaging procedures such as CT scans. "Interventional procedures," in general terms, are procedures designed to correct problems in the heart or arteries, such as clearing blockages.

16. Traditionally, hospital services for cardiology patients have been provided only in a hospital on either an in-patient or an out-patient basis. For instance, cardiology patients at Baptist Health may be admitted to the hospital for in-patient services, typically including overnight stays, or they may be admitted on an out-patient basis for services that typically do not require an overnight stay. In recent years, however, cardiological procedures that once required hospital admission may be performed

at a stand-alone cardiology facility known as a "cath lab." LRCC has had a cath lab for 5 years. The LRCC cath lab provides diagnostic and peripheral interventional procedures and competes directly with area hospitals for patients for these services. The peripheral interventional procedures performed outside of hospitals are those that involve low risk of complication and therefore do not require immediate access to hospital facilities.

17. This case involves the full range of interventional cardiology heart procedures that Baptist Health provides on either an in-patient or out-patient basis.

18. Medicare, Medicaid and private insurance payors pay separately for the technical, or facility, fee, which is for the services of the hospital or cath lab, and for the professional, or physician, fee. These are sometimes known as the "technical component" and the "professional component" of reimbursement payments.

19. When a patient needs an interventional cardiology procedure that requires hospital services, which is any interventional procedure involving the heart and many of the peripheral interventions, there is no reasonable substitute. The patient requires both a hospital and a cardiologist.

20. If the cardiologist could provide the service outside of a hospital, then the service would be outside of the relevant product market, and the cardiologist would have an economic incentive to provide the service in his or her office or clinic.

21. If a hospital could provide the service without a cardiologist, then the service would be outside the relevant product market.

22. The relevant product is those medical services that cardiology patients receive exclusively in a hospital from a cardiologist. These include all interventions involving the heart and the more complex interventions involving peripheral arteries and organs.

23. That patients obtain these cardiology services only in conjunction with associated hospital services means that the relevant cardiology services and hospital services are not distinct products for purposes of antitrust analysis. See *Jefferson Parish Hosp. Dist. No. 2. v. Hyde,* 466 U.S. 2, 43 (1984) (O'Connor, J., concurring).

24. Cardiologists and hospitals collaborate to deliver these services to cardiology patients because both the physician and the facility are essential to the patients. Collaborating groups of hospitals and cardiologists are rivals of other groups for cardiology patients. Plaintiffs routinely collaborate with Arkansas Heart Hospital in providing services to cardiology patients, while other cardiologists routinely collaborate with Baptist Health and seek to serve the same population. In this manner plaintiffs compete with Baptist Health in the relevant market.

25. The medical procedures that require hospital services in conjunction with cardiology services are described by reference to Diagnostic Related Groups ("DRGs"), which are the universally recognized billing codes for hospitals and physicians for health care, both for private insurance and for Medicare and Medicaid purposes. The specific DRGs in the relevant market include, but are not limited to, the following DRGs as defined in 2007: DRG 556, 555, 124, 125, 554, 558, 515, 138, 518, 557, 479, 552, 553, 139, and 551. The product market includes any

additional medical procedures for which patients obtain cardiology services only in conjunction with hospital services.

How Patients Pay for the Relevant Medical Procedures

26. Patients do not typically pay directly for health care; they rely on private insurance or government insurance benefits.

27. There are, therefore, two separate health insurance markets, depending on who pays for medical care. One market is government programs, most significantly Medicare and Medicaid. Patients in this market have free choice of providers, and the providers must accept the government benefit in full payment for service. Baptist Health and the plaintiffs are in this market. There are substantial market data available for Medicare-paid cardiology services in hospitals.

28. The other market is private insurance. Patients in this market typically have employer-sponsored group health insurance plans, but it includes federal employees as well as those individuals who purchase individual health insurance policies. In addition, many employers provide self-insurance plans in which the employers provide the health insurance benefits themselves, using an insurance company such as BCBS as a Third Party Administrator to manage the plan. Even in these cases, however, the employer usually will have an insurance policy in place as a limit to its liability for health care benefits under the plan.

29. The private insurance market is dominated by "managed care" products, which have

largely replaced traditional "indemnity" insurance in Arkansas.

30. In order to obtain the full benefit of the employer's group insurance plan, private insured patients in managed care plans must use the health care providers (both hospitals and doctors) that are "in network." Patients may go out of network but typically will pay more for service as a consequence. In *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1055 (8th Cir. 1999), the Court stated: "[T]he issue of access to a provider through an insurance plan is determinative of patient choice. Essentially, the evidence shows that patients will choose whatever doctors or hospitals are covered by their health plan."

31. A privately insured patient's choices of hospital and doctor for the cardiology services at issue in this case are largely constrained and determined by the hospitals and physicians included in the network utilized by his or her health plan.

32. The government-insurance and private-insurance markets are separate markets because patients cannot substitute one for the other regardless of price differences. Patients obtain Medicare or Medicaid based on age or income; these government benefits cannot be "purchased." Medicare patients could choose to be covered by private insurance rather than Medicare, but this would be irrational in almost all cases because Medicare is for the most part a government benefit to those who qualify.

33. Because of the division of the health care market into segments based on who pays for the services, there are two separate insurance markets for hospital services for cardiology patients –

government-benefit insurance and private insurance -- that exist in the same geographic footprint.

34. Of the total population in the Little Rock market (as defined below) and in the state of Arkansas, between 15% and 20% of adults are uninsured. They either pay for health care out of their own pockets, or they rely on indigent care or no care. These people are not in either product market. Of the 80% to 85% of the total population who are covered by private insurance or government insurance, roughly half fall into the government-insurance market and half fall into the private-insurance market.

35. This case involves the private insurance market, the hospital services market, and the cardiology services market. The first relevant product market at issue in this lawsuit (a market to be examined for competitive injury) is the market for cardiology procedures obtained in hospitals by patients covered by private insurance. In general, this product market includes all interventions involving the heart and the more complex peripheral interventions.

36. The second relevant product market at issue in this lawsuit (also to be examined for competitive injury) is the market for private health insurance. This market includes group health insurance plans, individual health insurance plans and employer self-insured health plans.

37. People requiring service in these markets cannot obtain a reasonable substitute outside of them. There is no cross-elasticity of supply between those in these markets and other service providers, so pricing in these markets is not constrained by other sources of supply.

38. The hospital services market in general (as opposed to for cardiology procedures) is also a subject of inquiry in this lawsuit, but plaintiffs do not assert distinct injury in this market. This general hospital services market is a source of defendants' market power that has been used for anticompetitive purpose and effect.

THE RELEVANT GEOGRAPHIC MARKET

39. The relevant geographic market for this case is the cities of Little Rock and North Little Rock. This geographic market, as defined, may be called "Little Rock" in this complaint. This is the area in which this lawsuit analyzes competition in both the market for cardiology procedures obtained in hospitals by patients covered by private insurance and the market for private health insurance.

40. A relevant geographic market for antitrust purposes is not defined by the service area or trade area of the parties to the lawsuit. Instead it is defined by the geographic area in which consumers can obtain reasonable substitutes for the relevant product or service.

41. Cardiology patients in Little Rock overwhelmingly seek medical procedures that require hospital services from one of the hospitals in Little Rock that offers these procedures, including Baptist Health (in both Little Rock and North Little Rock), Arkansas Heart Hospital, St. Vincent's Infirmary (in both Little Rock and North Little Rock), UAMS and Arkansas Children's Hospital, which handles only pediatric cases. Baptist Health includes both Baptist-Little Rock, the flagship

hospital, and its companion, Baptist-North Little Rock.

42. Cardiology patients in Little Rock who seek hospital services do not leave Little Rock for hospitals outside of these cities because these patients do not consider hospitals outside of Little Rock to be reasonable substitutes for Little Rock hospitals with respect to cardiology procedures.

43. The hospitals in surrounding areas that offer cardiology services, such as Conway Regional Medical Center and hospitals in Searcy, are not equipped to receive significant numbers of cardiology patients from Little Rock, and some of the more sophisticated cardiology procedures are available only at Little Rock hospitals. For this reason, Little Rock hospitals attract patients in large numbers from outside of Little Rock for cardiology procedures, but Little Rock cardiology patients rarely go outside of the Little Rock market for these services.

44. In addition, employers located in and around Little Rock offer health plans that include Little Rock hospitals. Cardiology patients as a rule do not travel more than a few miles for the acute medical procedures involved in this case if they have a choice, and those who do have a choice and the means and desire to travel for these procedures are far more likely to choose to go to major cardiology centers outside of Arkansas, such as the Cleveland Clinic or hospitals in Houston, New York or Chicago, than to places such as Russellville, Pine Bluff, or Hot Springs. Medical insurance is a highly valued employee benefit. An employer that adopted a plan causing employees to travel to receive medical care would find itself at a disadvantage in attracting the

best employees. For this reason, distant providers are not in the relevant geographic market.

45. Hospital Cost Utilization Project (HCUPS)[1] data by zip code show that 99.5% of privately insured cardiology patients from the area with zip codes beginning with the three digits 722, which is Little Rock proper, use hospitals within Little Rock. Of the privately insured cardiology patients who reside in Little Rock and its surrounding areas, which are covered by zip codes that begin with 722 and 721, 84.7% use hospitals in Little Rock. The remaining 15.3% of cardiology patients in these zip codes use hospitals in North Little Rock and Conway.

46. The area covered by the 722 and 721 three-digit zip codes is larger than the geographic market at issue, which is the cities of Little Rock and North Little Rock. On information and belief, the percentage of cardiology patients in Little Rock and North Little Rock who use hospitals in Little Rock exceeds 85% and approaches 95%.

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[1] "The Healthcare Cost and Utilization Project (HCUP, pronounced "H-Cup") is a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ). HCUP databases bring together the data collection efforts of State data organizations, hospital associations, private data organizations, and the Federal government to create a national information resource of patient-level health care data." See http://www.hcup-us.ahrq.gov/overview.jsp. These data were purchased by plaintiffs from the Arkansas Department of Health.

Destinations of Little Rock Cardiac Patients

		Arkansas Health Region						
	Total	Central	East Northeast	North Northwest	South Northwest	Southeast	Southwest	West Northeast
	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]
	From 3-digit Zip Code 721							
Discharges	15,883	9,964	209	18	611	307	1,250	3,524
Percentage of Total	100.0%	62.7%	1.3%	0.1%	3.8%	1.9%	7.9%	22.2%
	From 3-digit Zip Code 722							
Discharges	8,938	8,890	4	5	14	7	6	12
Percentage of Total	100.0%	99.5%	0.0%	0.1%	0.2%	0.1%	0.1%	0.1%
	Totals from 3-digit Zip Codes 721 and 722							
Discharges	24,821	18,854	213	23	625	314	1,256	3,536
Percentage of Total	100.0%	76.0%	0.9%	0.1%	2.5%	1.3%	5.1%	14.2%

47. Using the data for all patients, as opposed to privately insured patients, shows that 76% of all patients from the 722 and 721 zip codes use hospitals in Little Rock. Thus privately insured patients in this area are significantly more likely than government-insured patients to seek their hospital care from Little Rock hospitals.

48. Little Rock is the area from which Baptist Health draws its largest share of cardiology patients and in which it faces its most significant competition for cardiology patients.

49. Little Rock is also where Arkansas's cardiologists are located. According to information from the Arkansas Medical Board, there are 138 cardiologists in the entire state of Arkansas, and 51 of them reside in the Central Public Health Region cities of Conway, Hot Springs, Little Rock, North Little Rock, and Pine Bluff. Of these 51, 41 are in Little Rock and North Little Rock. This is 80% of the total from the Region, and 29% of the state-wide total. As between Little Rock and North Little Rock, 33 cardiologists are in Little Rock and 8 are in North Little Rock. The reason why cardiologists reside in the Little Rock market in these numbers is that it is

the largest market for cardiology services in the state, retaining the overwhelming majority of Little Rock patients who seek cardiology services and drawing large numbers of patients from around the state for medical procedures that require hospital services.[2]

50. In addition, a larger percentage of the cardiologists who perform in- hospital procedures known as interventional cardiology, including the plaintiffs, are located in Little Rock rather than outside of Little Rock.

51. The 722 zip codes contain 15 of the state's 55 hospitals (27% of the total) and 2,712 of the state's 7,827 hospital beds (35%). Most of the hospitals outside of the Little Rock are primary and secondary care hospitals that do not provide acute care. The 722 zip-code-area hospitals serve not only 99.5% of residents in Little Rock, but also a large percentage of residents from around the state who need cardiology services in hospitals.

MARKET STRUCTURE

52. Cardiology patients who require hospital services require three elements for their medical care: a hospital, a cardiologist and a health insurance plan. Cardiologists, hospitals and insurers all compete to serve the same patients.

53. Until the early 1990's patients who had private insurance were typically covered by traditional indemnity plans, which permitted the

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[2] Because interventional cardiology procedures can result in a dissection of a vein or artery, they must be performed in a facility that has a cardiac surgery facility. This implies an acute care hospital, the type typically found only in larger towns and cities.

patient free choice of cardiologist and hospital. The insurance plan would make the same payment, called the usual and customary charge, to every health care provider, for the same service. Medicare and Medicaid operated similarly.

54. Since the early 1990's, private health insurance has moved from indemnity plans to networks, which limit the included health care providers. Indemnity plans are an insignificant component of the market. A network is a group of health care providers, including hospitals and physicians, who are assembled for use by a health insurance managed care plan. Several different managed care plans may use the same network of providers.

55. The two principal forms of managed care plans, usually provided through one's employment, are health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs"). Many of the largest employers self-insure and, in those cases, their health plans are managed by Third Party Administrators ("TPAs"), which typically are insurance companies. As a practical matter, there is little difference between these self-insured (also known as retained risk) plans and the HMO and PPO products offered by insurers. Typically, employers cap their exposure to self-insurance losses with a stop-loss insurance product that insures them against the risk of excessive health care costs.

56. HMOs, PPOs and self-insured plans operate through networks of health care providers, including physicians and hospitals. A network is created by contracts with the health care providers for the terms of payment and participation in the

network. Whereas in traditional indemnity plans the payment for health care was based on the usual and customary charge, in a network the terms of payment are based on a contractual "allowable charge," which is a significant discount from the provider's actual charge for the service.

57. In an HMO, if the insured obtains medical services through specified health care providers that are in the HMO network, the insured pays only a specified per-visit charge or no charge. But if the insured patient member goes "out of network," *i.e.*, to a provider not a member of the HMO, the patient may be required to pay all or a substantial portion of the provider's actual (as opposed to allowed) charges. In a similar fashion, in a PPO, if the insured goes to a doctor in the PPO network, the insured patient is required to make only a modest "co-payment," often in the range of 10% of the allowed charges up to an annual limit. However, if a PPO member chooses a physician who is "out of network," the insured may face a co-pay up to 50% of the physician's actual (as opposed to allowed) charges, except in the case of emergency care. For the vast majority of patients, the unreimbursed portion of "out-of-network" physician and hospital charges is so high that patients will seek treatment only from health care providers in the plan's insurance network, as the Eighth Circuit recognized in *FTC v. Tenet Health Care, supra*.

58. The success of an insurance network depends in large measure on the identity of the participating health care providers: an insurance company cannot offer a competitive product unless the network contains a mix of doctors and hospitals that are convenient, competent and cover the full

range of anticipated health care needs of the employees of the company that will purchase the plan. Without an attractive mix of providers in a network, an insurance company cannot successfully market a health plan product.

59. The success of health care providers also depends in large measure on access to or inclusion in health plan networks, because the networks determine the providers with whom their insured patients will do business.

60. Defendants have linked their market power in the hospital and insurance markets through their exclusive dealing arrangements. In these arrangements, defendants' insurance customers must use Baptist Health hospital services, which freezes out hospital competition for Baptist Health. Particularly before the Any Willing Provider statute was permitted to be enforced in Arkansas in 2005, Baptist Health refused to do business with any insurance company other than the defendants, and this prevented entry of new insurance competition and forced the exit of insurers who were in the market. This exclusive-dealing arrangement restrained competition in both the hospital and private insurance markets and continues to have an effect on the market, because it helped vault all defendants into the monopoly positions that they currently enjoy.

61. When the defendants introduced their managed care products into the market, USAble created a network of providers called "Arkansas FirstSource Network." The defendants used this network for all of their health insurance plans. Specifically, BCBS and USAble used it for their PPO plans, and HMO Partners used it for its HMO plans.

The defendants also used this network for their self-insured plans. From the creation of these managed care products in the early to mid-1990s, this single network was the sole network used for the defendants' various PPO, HMO and self-insured plans. When the defendants were forced to open up their networks in 2005 when the Any Willing Provider Act was permitted to operate in Arkansas, BCBS and USAble created a separate network, "True Blue," for admission of any willing providers, including the plaintiffs. The defendants converted FirstSource to a network that serves only self-insured plans, and they have maintained FirstSource as an exclusive network with Baptist Health as a hospital provider.

62. The plaintiffs were admitted into the FirstSource network when the network was first established, and they remained in that network until their unlawful exclusion in 1997. The defendants have never permitted the plaintiffs back into the FirstSource network.

63. On information and belief, the plaintiffs are the only group of specialists in the market who were excluded from the FirstSource network.

64. The exclusive-dealing arrangement between Baptist Health and BCBS is the most salient feature of the health care market in Little Rock and has been for a decade.

65. This structure of the Little Rock health care market is well known and documented nationally. The Center For Studying Health System Change, www.hschange.org, funded by The Robert Wood Johnson Foundation and affiliated with Mathematical Policy Research, Inc., has published a series of reports on the health care market in Little

Rock based on interviews and site visits conducted every two years beginning in September 1996. These reports are authoritative works on the history of the health care market in Little Rock, and they confirm the market power of the defendants in the relevant market as detailed in this complaint. These reports are available at no charge at the web site cited above. Each of the reports discussed below is incorporated herein by reference.

66. The Report of the first site visit, "Health System Change in Little Rock, Arkansas," published in July 1997 based on a site visit in 1996, begins with the defendants' combination as the most significant fact about the Little Rock health care market:

> Perhaps the most potent force in the market today is the recent alliance between two established, home-grown institutions: Little Rock-based Baptist Health, the largest hospital system in central Arkansas, and Blue Cross and Blue Shield of Arkansas (BCBSA), which covers close to half of all commercially insured lives in the metropolitan area. These entities joined forces in 1994 to form the area's most highly subscribed HMO. Baptist Health is also the preferred hospital provider for BCBSA's sizeable PPO business, a business that stands to gain from the insurer's successful bid for the newly combined state employee and public teacher pool [which included 70,000 employees].

Exhibit A at page 1; page 7.

67. The Report anticipated that new providers and insurers would enter the Little Rock market because health care costs were high. "While established insurers and providers are looking for new ways to control health care costs, national health care companies are entering the market and seeking to unseat the dominant local players by driving down health care spending." *Id.* at 1. "All eyes are . . . on the Arkansas Heart Hospital, an institution being built by MedCath, . . . which opened its doors in early 1997 and is positioning itself to lure lucrative cardiology patients away from several other area hospitals." *Id.* at 2. "National health insurance companies are also a growing presence in the Little Rock market. The companies include . . . Healthsource; Prudential . . . and United HealthCare." *Id.*

68. BCBS dominated the insurance market, but it did not have a monopoly at that time, and it had been subject to competition: "BCBSA, a not-for-profit corporation that dominates the local insurance market, covers more than 40 percent of commercially insured insured lives in the area. However, like the hospital sector, control of Little Rock's HMO market is mixed, with an increasing number of national, for-profit insurance companies and HMO chains, including United HealthCare and Healthsource, making substantial inroads over the last several years." *Id.* at 4.

69. Hospitals and insurers had begun to align in networks, most of which were not exclusive. The defendants' alliance, however, was exclusive and

was the most powerful. The "most powerful area health system is Baptist Health," and "Baptist Health has secured its position in the Little Rock market [through] its strategic partnership with BCBSA, and its physician affiliates are equity partners in the area's biggest HMO, Health Advantage." *Id.* at 8. "In return for its equity share, Baptist retains the exclusive contract for general inpatient services for the HMO's 40,000-plus members. In addition, Baptist serves as the preferred provider for BCBSA's PPO products." *Id.*

70. Baptist's most significant competitor was St. Vincent, which was aligned with Healthsource, but that arrangement suffered from high costs, and there was "a rocky relationship" between St. Vincent's and Healthsource. *Id.* at 9. Another competitor of Baptist Health was the "emerging presence of Columbia/HCA," which bought Doctor's Hospital in 1994. *Id.* AHH opened in March 1997 "and poses a significant threat [to local institutions] because cardiology programs are reportedly big moneymakers." *Id.* at 10.

71. Even though AHH did not have a managed care arrangement, at the time it was able to compete for traditional indemnity patients. "Arkansas Heart Hospital has yet to secure a managed care contract, and its investors anticipated limited success in this regard given the equity position of its major competitors in two of the area's most highly subscribed HMOs." But this "does not restrict [the] ability to compete for patients enrolled in traditional health insurance plans." The opening of AHH also "has generated significant competition for specialized nursing and mid-level technical staff." *Id.*

72. In the insurance market, Blue Cross and HMO Partners faced significant competition and actually suffered financial losses in the market. Three relatively new national health insurers had entered the market since 1994, creating "increased marketing efforts and premium competition." In 1996, "BCBSA announced a $22 million operating deficit and a $5 million operating deficit for Health Advantage. This is another indication that competitive pressure may be holding down premiums." *Id.* at 12.

73. Based on the market conditions in 1996, the 1997 Report predicted that competition and "the pace of change in Little Rock is likely to increase." *Id.* at 18. This prediction did not come to pass.

74. The 1999 Report, based on a September 1998 site visit, observed that despite earlier expectations, "national firms have not usurped locals' market share." Exhibit B at 1. The defendants, with their exclusive arrangement and market power, now faced "few outside pressures." *Id.* "During the past two years, the anticipated threat of outside entrants failed to materialize, as national firms did not capture significant market share from locally based competitors. Many of these firms have either reduced their presence or retreated from the market altogether." *Id.* at 3.

75. In the insurance market, the Report found that Prudential and Healthsource were backing away from the market and that, "despite outside pressures, Arkansas Blue Cross Blue Shield has retained its dominant position in the market." *Id.* at 3. Its "partnership [with Baptist], and similar arrangements developed with other hospitals around the state, gave Arkansas Blue Cross Blue Shield

added leverage to win managed care contracts." *Id.* at 4.

76. AIIH had obtained about 10 to 20 percent of cardiac surgical volume away from the two major Little Rock hospital systems, but its "market power ultimately will depend on its ability to secure managed care contracts. To date, however, most of [its] volume has come from Medicare." *Id.* at 3.

77. The third Report, from a site visit in December 2000, is called, "Hopes Dim for More Competition." See Exhibit C. It begins on page 1 with an unvarnished assessment of the lack of effective competition against the defendants' dominant hospital/insurer combination:

> In 1998, Little Rock health plans and providers were optimistic that partnerships with national firms would bolster their ability to challenge the powerful positions of the market's dominant health plan and provider system, Arkansas Blue Cross Blue Shield (ABCBS) and Baptist Health System. Two years later, optimism has faded as many of these would-be competitors face mounting financial and operational problems, eroding their competitive potential. The departure of various health insurers since 1998 has further constrained competition. As health care costs increase and premiums rise, many observers fear that health insurance coverage will become increasingly prohibitive for some consumers, ...

78. The Report found that much of Blue Cross's market strength "derives from its preferred provider organization (PPO), which has more than 2.5 times the enrollment of its HMO, or approximately 440,000 enrollees statewide." *Id.* at 2. Two of the defendants' health-insurance competitors were on "questionable footing" and another, CIGNA, "pulled out of the Arkansas HMO market." *Id.* at 2.

79. The defendants' market power had effectively eliminated competition in the market: "In all, approximately 40 insurers have reportedly left the Arkansas market since 1998. Although it is unclear whether all of these insurers offered health insurance coverage, most observers agree that health plan competition has decreased." *Id.* at 2.

80. With respect to hospitals, the Report found: "Competition has also faltered in Little Rock's hospital market, and Baptist has maintained a significant competitive advantage." *Id.* at 2.

81. The Report for 2001 goes on to detail the increased health insurance charges and health care costs in the Little Rock market, which had continued without challenge from effective competition. The 2003 and 2005 Reports detail the same anticompetitive results of the defendants' exclusive alliance.

82. Although several hospitals and insurers made alliances throughout the 1990s in Little Rock, only the defendants had an exclusive alliance. The defendants began the 1990s as powerful and dominant providers of hospital services and private insurance, and their alliance squelched competition in these fields so that by about 2001 they were monopolists.

83. That Baptist Health was exclusively available to BCBS and HMO Partners for insurance networks prevented any insurance competitor from creating a network that included Baptist Health, and this destroyed competition in the private insurance market. Premiums rose, which caused employers to abandon traditional indemnity plans at increasing rates until they became virtually nonexistent. The absence of traditional indemnity plans simply reinforced the market power of Baptist Health because fewer patients covered by BCBS and HMO Partners' plans could choose to go to other hospitals, and this in turn reinforced the importance of Baptist Health to the defendants' insurance networks.

84. That BCBS and HMO Partners excluded all hospitals but Baptist Health (except for Arkansas Children's Hospital, which serves a pediatric population and is outside of the relevant market) from their insurance plans steered patients away from the excluded providers. Health care costs at Baptist Health rose because Baptist Health did not face effective competition.

85. Others have noted competitive concerns regarding the Little Rock health insurance and hospital services markets. The United States Department of Justice and Federal Trade Commission held hearings in which they examined the structure of the health care and insurance markets in Little Rock.[3] In opening remarks, Deborah Platt Majoras, Deputy Assistant Attorney

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[3] DOJ/FTC Hearings on Health Care and Competition Law and Policy, Federal Trade Commission Conference Center, Washington, D.C., February 28, 2003

General, Antitrust Division, U.S. Department of Justice, noted with respect to the Little Rock market: "Understanding the competitive impact of alliances between multiple providers, and between providers and payors helps us to understand how such alliances may affect the market power of their members, and whether they may produce anticompetitive results in the form of higher prices or lower quality... [A]nother market fact to consider is that Arkansas Blue Cross Blue Shield has a significant share of the health care coverage market in Little Rock. In subsequent hearings, we will consider a wide range of concerns relating to the possible market problems that could result from a single third-party payor achieving market power as a purchaser of health care services."

DEFENDANTS' MARKET POWER
HOSPITAL SERVICES

86. Five hospitals currently provide cardiology services in the Little Rock market: Arkansas Heart Hospital ("AHH"), Baptist-Little Rock, Baptist-North Little Rock, St. Vincent Infirmary and Southwest Regional Medical Center. The American Hospital Directory maintains data showing Medicare market shares for these hospitals, reported below, for all hospital services, including cardiology. Because Medicare patient choice is not network constrained, Medicare patient choices provide an indication of what market shares for hospital services would be in a competitive market.

87. Omitted from these data are procedures provided by specialty surgical centers, Children's Hospital, a pediatric specialty hospital, and UAMS, a

teaching and indigent-care hospital, because these hospitals are not comparable to the other acute care hospitals in the market that provide reasonable alternatives for cardiology patients. Specialty surgery centers are not hospitals and do not provide the cardiology services at issue.[4] Children's Hospital provides pediatric services, whereas the overwhelming majority of cardiology patients with private insurance are adults. UAMS has a very small cardiology program that primarily treats Medicare, Medicaid and indigent patients and is classified as a "low volume hospital" by HealthGrades.[5]

88. All of the data in this analysis were obtained on March 5, 2008, from the American Hospital Directory ("AHD") website,[6] and are from annual reporting periods ending for the most part in 2006.

89. AHD reports inpatient days in three categories, Medicare, Medicaid and other. The "other" group contains self-paid medical care, indigent care and medical care paid by insurance. Since a small fraction of all patients are self-paid or indigent, the category of "other" primarily represents the private-insurance market.

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[4] Some hospitals contain out-patient centers, and these are included in the data.

[5] HealthGrades provides ratings of the quality of hospital programs (cardiology) based on complication and mortality rates and length of stay. See http://www.healthgrades.com.

[6] The American Hospital Directory, www.AHD.com, compiles and publishes hospital data from the Centers for Medicare and Medicaid Studies ("CMS"), an agency of the U.S. Department of Health and Human Services, from Hospital Cost Reports ("HCR") and Medicare Provider Analysis and Review ("MEDPAR") files.

90. The following chart shows the private-insurance market share for each of the five hospitals in the relevant market.

Market Share Analysis for Little Rock Hospitals

Hospital name	Beds	"Other" Inpatient Days	"Other" Inpatient Percent
Arkansas Heart Hospital	84	5,010	4%
Baptist- Little Rock	672	66,156	52%
Baptist- North Little Rock	190	19,621	15%
Southwest RMC	102	2,047	2%
St. Vincent Infirmary	614	35,334	28%
Total Market	1662	128,168	100%
Baptist System	862	85,777	67%

91. As a whole, the Baptist Health System accounts for 67% of all insurance inpatient days within the market, 52% of which come from its flagship hospital in Little Rock. These inpatient shares are in marked contrast to the number of beds available: the Baptist system, as a whole, accounts for less than 52% of all beds in Little Rock, and Baptist Little Rock accounts for only 40%. The only hospital comparable in number of beds to Baptist Little Rock is St. Vincent Infirmary, which only captures a 28% market share (a number that includes St. Vincent's substantial indigent care volume and therefore, on information and belief, is skewed upward for that hospital). Accordingly, the data show that the market for privately insured patients in Little Rock is dominated by the Baptist Health System with at least 67% share of the total market.

92. Based on Medicare data, Baptist Health holds more than 50% market share in the Medicare market for inpatient cardiology services. AHH has a dominant market share for cardiovascular surgery in the Medicare market.

[See chart next page]

All Data is from AHD.com and pertains only to Medicare patients

			Inpatient			
City	**Hospital**	**# Acute Care Beds**	**# Cardiology Patients**	**Mkt Share Cardiology Patients**	**# Cardiovascular Surgery**	**Mkt Share Cardiovascular Surgery**
Little Rock	Ark. Heart Hospital	84	1115	23%	2483	45%
Little Rock	Baptist Health MC- LR	672	1762	36%	1307	24%
Little Rock	Baptist Health MC-NLR	190	902	18%	763	14%
Little Rock	St. Vincent Infirm. MC	614	1038	21%	956	17%
Little Rock	Southwest RMC	102	90	2%	36	1%
	Baptist Health System	862	2664	54%	2070	37%
	Little Rock Total	1,662	4,907		5,545	

93. Comparing the government and private insurance market shares of these hospitals shows that Baptist Health's insurance market share substantially exceeds its Medicare market share. Because Medicare market shares represent patient choices, rather than simple availability under a health plan, the Medicare market shares are a proxy for how the market would look if it were subject to free and open competition. In a competitive market AHH would have a significantly higher market share in insured patients, and Baptist Health would have a lower market share. That Baptist Health has the highest market share of privately insured patients is a consequence of the anticompetitive network decisions by BCBS in combination with Baptist and HMO Partners.

94. Baptist enjoys more of the high-paying insurance market for cardiology patients than it would in a competitive market structure, and AHH and St. Vincent are forced to provide more of the lower-paying government-benefit care. The percentage of private-insurance patients to Medicare and Medicaid patients is known as the "payor mix" in the health care industry.

HEALTH INSURANCE MARKET

95. AM Best, a leading and authoritative source of insurance industry market information, reports data on the market shares of insurance companies for particular lines of insurance nationally and by state, including the state of

Arkansas.[7] These data are available for the years 2002 through 2006. On information and belief, the reported data for the entire state of Arkansas hold true in the Little Rock market. The particular lines of insurance that are part of the product market for hospital services are comprehensive medical plans for both individuals and groups and the federal employees health benefit plan. There are other lines reported in AM Best, such as Medicare gap coverage and dental plans, but they are outside of the relevant market. All reported data for the individual, group and federal employee plans are for either HMO or PPO plans. On information and belief, there are no traditional indemnity plans in the data.

96. Even though the Blue Cross HMO plans are reported separately from the Blue Cross PPO plans because the HMO is operated by HMO Partners, AM Best also combines the information for HMO Partners with the BCBS PPO information, and reports the total information for a company that it identifies as "AR BC/BS and Baptist Medical System," which includes the combined shares of HMO Partners, the captive HMO insurer of BCBS and Baptist Health, owned through their wholly owned subsidiaries, and the PPO shares of BCBS. As a matter of economic reality and for purposes of antitrust analysis, this combination of BCBS, as reported by AM Best, is the appropriate information to use in assessing the market power of the defendants in the private health-insurance market. All defendants operate in combination to serve the

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[7] AM Best collects its data from filings by State Insurance Commissions to the National Association of Insurance Commissioners, SEC filings and other sources. It is considered an authoritative source of such information.

interests of their owners and the true economic actors, Baptist Health and BCBS.

97. The data below report the combined HMO and PPO information and compare market shares for the other insurers that offer competing products. The market shares are calculated based on premium revenue. The numbers for each of the market actors are, on information and belief, identifying numbers used in the insurance industry.

98. Based on the information from AM Best, the combined market share of the defendants ranged from a low of 77.59% in 2002 to a high of 89.48% in the most recent year. The combined market power of the defendants in the insurance market has increased steadily according to this information. The information is as follows:

[See charts next pages]

Arkansas 2001			
Lines	Companies	Health premiums earned (000s)	Health premiums market share
Comprehensive-Individual	64050 QCA Health Plan Inc	111,303	55%
Comprehensive-Individual	70971 AR BC/BS and Baptist Medical System	91,643	45%
Comprehensive-Group	70971 AR BC/BS and Baptist Medical System	621,677	83%
Comprehensive-Group	70980 UnitedHealth Group Incorporated	111,966	15%
Comprehensive-Group	70972 Aetna U.S. Healthcare Group	15,086	2%
Comprehensive-Group	70976 CIGNA Corporation	307	0%
Federal Employees Health Benefit Plan	70971 AR BC/BS and Baptist Medical System	132,968	100%
Total Sales and Market Share:	70971 AR BC/BS and Baptist Medical System	846,288	78.00%

Arkansas 2002			
Lines	Companies	Health premiums earned (000s)	Health premiums market share
Comprehensive-Individual	70971 AR BC/BS and Baptist Medical System	123,460	100%
Comprehensive-Group	70971 AR BC/BS and Baptist Medical System	535,668	70%
Comprehensive-Group	70980 UnitedHealth Group Incorporated	145,964	19%
Comprehensive-Group	64050 QCA Health Plan Inc	82,212	11%
Comprehensive-Group	70976 CIGNA Corporation	363	0%
Federal Employees Health Benefit Plan	70971 AR BC/BS and Baptist Medical System	132,351	100%
Total Sales and Market Share:	70971 AR BC/BS and Baptist Medical System	791,479	77.59%

Arkansas 2003			
Lines	Companies	Health premiums earned (000s)	Health premiums market share
Comprehensive-Individual	70971 AR BC/BS and Baptist Medical System	141,111	100%
Comprehensive-Group	70971 AR BC/BS and Baptist Medical System	575,366	75%
Comprehensive-Group	70980 UnitedHealth Group Incorporated	122,539	16%
Comprehensive-Group	64050 QCA Health Plan Inc	69,531	9%
Federal Employees Health Benefit Plan	70971 AR BC/BS and Baptist Medical System	143,047	100%
Total Sales and Market Share:	70971 AR BC/BS and Baptist Medical System	859,524	81.74%

Arkansas 2004			
Lines	Companies	Health premiums earned (000s)	Health premiums market share
Comprehensive -Individual	70971 AR BC/BS and Baptist Medical System	162,448	100%
Comprehensive -Group	70971 AR BC/BS and Baptist Medical System	509,049	81%
Comprehensive -Group	70980 UnitedHealth Group Incorporated	60,190	10%
Comprehensive -Group	64050 QCA Health Plan Inc	57,508	9%
Federal Employees Health Benefit Plan	70971 AR BC/BS and Baptist Medical System	165,459	100%
Federal Employees Health Benefit Plan	70972 Aetna U.S. Healthcare Group	18	0%
Total Sales and Market Share:	70971 AR BC/BS and Baptist Medical System	836,956	87.67%

Arkansas 2005			
Lines	Companies	Health premiums earned (000s)	Health premiums market share
Comprehensive-Individual	70971 AR BC/BS and Baptist Medical System	163,642	100%
Comprehensive-Individual	70929 Health Care Service Corp	200	0%

Comprehensive-Group	70971 AR BC/BS and Baptist Medical System	508,695	81%
Comprehensive-Group	64050 QCA Health Plan Inc	61,062	10%
Comprehensive-Group	70980 UnitedHealth Group Incorporated	48,686	8%
Comprehensive-Group	70929 Health Care Service Corp	7,732	1%
Comprehensive-Group	07677 Medical Savings Insurance Company	1,387	0%
Comprehensive-Group	70964 WellPoint Inc	233	0%
Federal Employees Health Benefit Plan	70971 AR BC/BS and Baptist Medical System	169,348	100%
Total Sales and Market Share:	70971 AR BC/BS and Baptist Medical System	841,685	87.59%

Arkansas 2006			
Lines	Companies	Health premiums earned (000s)	Health premiums market share
Comprehensive-Individual	70971 AR BC/BS and Baptist Medical System	158,917	100%
Comprehensive-Individual	70929 Health Care Service Corp	60	0%
Comprehensive-Group	70971 AR BC/BS and Baptist Medical System	519,835	84%
Comprehensive-Group	64050 QCA Health Plan Inc	61,788	10%
Comprehensive-Group	70980 UnitedHealth Group Incorporated	27,638	4%
Comprehensive-Group	70929 Health Care Service Corp	10,664	2%
Comprehensive-Group	70883 Mercy Health Plans Inc	931	0%
Comprehensive-Group	70964 WellPoint Inc	190	0%
Comprehensive-Group	07677 Medical Savings Insurance Company	5	0%
Federal Employees Health Benefit Plan	70971 AR BC/BS and Baptist Medical System	182,461	100%

Total Sales and Market Share:	70971 AR BC/BS and Baptist Medical System	861,213	89.48%

99. Baptist and BCBS combined to form HMO Partners as a 50/50 venture in 1993. In 1997 BCBS had less than 50% of the commercial health insurance market in Arkansas, and the dominant health insurance product in the Arkansas was indemnity insurance in which the patient selected her health providers and the insurer simply paid each provider's "usual and customary" charges.

100. In a market dominated by indemnity policies, there is no advantage to an exclusive insurer-health provider alliance like that among the defendants because the patient has free choice. However, in a managed care network, an insurer has the power to steer patients to preferred providers. In the late 1990's the Arkansas health insurance market transitioned from an indemnity market to a managed care model.

101. By 2001, according to the AM Best data, the Baptist/Blue Cross insurance combination had 83% of the group insurance market and 78% of the total private-insurance market, and by 2006 the shares had grown to 84% of the group market and 89% of the total market.

102. Between 2001 and 2006, the period during which the defendants' market power expanded, there were numerous exits of other insurers from the private-insurance market in Arkansas, as shown by the AM Best data. Aetna exited this market entirely in 2002. Qualchoice ("QCA Health Plan"), which was the market leader in the individual line in 2001, exited that line of business in 2002, leaving Baptist/Blue Cross with 100% of that sub-market for every year thereafter.

103. Prudential, Principal, Trustmark and Humana all stopped offering health insurance in Arkansas between 1996 and 2003.

104. CIGNA exited the Arkansas market in 2003.

105. When the Any Willing Provider statute was permitted to take effect in 2005, three insurers entered the Arkansas private health-insurance market, but they garnered barely 1% of the market, and the defendants' market share increased. An additional insurance company entered the Arkansas market in 2006, but the defendants' market share increased again, and United HealthCare's market share continued to fall to the point where it is no longer a major insurer in Arkansas.

THE RESTRAINT OF TRADE AND MONOPOLIZATION

106. Defendants' anticompetitive conduct in the relevant market has excluded competitors, restricted patient choice, increased prices, and harmed the health of privately insured cardiology patients, who have suffered increased mortality rates and adverse outcomes because of the absence of

competition. In collaboration with Baptist Health, BCBS and HMO Partners have used their market power as health insurers to exclude competition, including the exclusion of the plaintiffs from the market for hospital services for privately insured cardiology patients. Similarly, by using its power in the hospital market and refusing to deal with other insurers, Baptist Health has protected and increased the monopoly power of Blue Cross and HMO Partners. Baptist, HMO Partners and BCBS have taken actions that protect Baptist Health from competition, including competition from specialty hospitals like AHH, that would have offered patients health care choices and forced Baptist Health either to become a better competitor on price and service to patients or to lose market share.

107. The restraint of trade is the contract, combination, conspiracy and concerted action among monopolists. Baptist Health is the dominant hospital in Little Rock and by virtue of its size and long history is highly regarded. For a health insurer creating a network, Baptist Health is a "must have" hospital. This is because a large number of patients have a preference for Baptist Health and would be unlikely to choose a health network that did not include Baptist Health. Market entry by an insurer competing with BCBS or HMO Partners would be greatly facilitated if it had Baptist Health in its network, but greatly impeded if it did not. By refusing to deal with competitors of BCBS and HMO Partners before the effectiveness of the Any Willing Provider Act, Baptist Health erected a virtually insurmountable barrier to entry into the Little Rock health insurance market that benefitted and

continues to benefit the incumbents, BCBS and HMO Partners.

108. The refusal to deal was not unilateral; it was a fundamental part of the contract, combination, conspiracy and concerted action among the defendants.

109. In a competitive market it would be economically illogical for Baptist Health to deal exclusively with Blue Cross. Though Blue Cross, as the largest provider of patients, reasonably expects to receive the lowest prices from its network hospitals, there was no economic logic to Baptist Health's refusal to deal with other insurers. So long as Baptist Health had excess capacity and can accept additional patients, it made no economic sense to turn them away. Yet, this is precisely what Baptist Health did by refusing to negotiate with insurers other than Blue Cross.

110. BCBS and HMO Partners compensate Baptist Health for protecting their insurance monopoly by refusing to deal with other hospitals and paying Baptist Health above-market prices for hospital services. Though at first blush it might appear illogical for an insurer to pay higher prices, it is entirely economically logical if the price is compensation for protecting an insurance monopoly. BCBS and HMO Partners compete by maintaining barriers to market entry and not on the merits. The exclusive contract with Baptist Health is the barrier in Little Rock; BCBS and HMO Partners pay Baptist Health for this protection, and pass their higher costs on to insurance customers through premiums that are not constrained by competition. Patients pay more for health insurance and higher costs,

longer hospital stays, more adverse outcomes and higher mortality rates.

111. Baptist Health and its subsidiary exercise its market power in combination with HMO Partners and BCBS in order to insulate itself from competition in the market for hospital services, including the market for hospital services for privately-insured cardiology patients.

112. BCBS and its subsidiary exercise its market power in combination with Baptist Health and HMO Partners in order to protect Baptist Health from competition in the market for hospital services, including the market for hospital services for privately insured cardiology patients, in consideration of and in furtherance of the market dominance that BCBS achieved and maintained through its exclusive alliance with Baptist Health as hospital provider in the BCBS insurance products and markets.

113. HMO Partners exercised its market power in combination with BCBS, Baptist Health and their subsidiaries in consideration of and in furtherance of the market dominance that HMO Partners achieved and maintained through its exclusive alliance with Baptist Health as hospital provider in its HMO network, through its allegiance and loyalty to its owners and founders, BCBS and Baptist Health, and because BCBS and Baptist Health dominate and control the business of HMO Partners and cause HMO Partners to engage in conduct to further the combination and economic interests of BCBS and Baptist Health.

114. The defendants exercised their market power against the plaintiffs beginning in 1997, upon the opening of Arkansas Heart Hospital, in order to

stifle the competition that AHH presented to Baptist Health in the relevant market.

115. In 1993, Baptist Health was the largest hospital in Arkansas and Blue Cross was the largest health insurer. At that time both had significant competitors in the state and lower market shares than they currently enjoy.

116. In 1993 or 1994, in an effort to leverage their respective market dominance, Baptist Health and Blue Cross, through wholly-owned subsidiaries, created a jointly-owned and controlled corporation, HMO Partners, Inc., which in turn created an HMO marketed under the name "Health Advantage." Subscribers to Health Advantage could receive covered hospital services only at a Baptist Health facility and only from doctors in the Health Advantage network. Only subscribers to Health Advantage could obtain fully-insured services from Baptist Health. As a result of combining the insurance market power of Blue Cross with the hospital market power of Baptist Health, Health Advantage quickly became the largest HMO in Arkansas and Baptist Health quickly became the dominant health care provider.

117. Plaintiffs do not allege an actionable restraint of trade arising from the creation of HMO Partners. However, that combination created a third entity, HMO Partners, controlled by Baptist Health and BCBS, that could act in concert with the defendants to restrain trade in the hospital and private health insurance markets. In the alternative, by virtue of their creation, ownership and control of HMO Partners, it was and remained a captive instrumentality of Baptist Health and BCBS.

118. Baptist Health Center Little Rock is an acute care hospital, offering a complete range of hospital and surgical service, including services for cardiology patients, which are among the most profitable hospital services that a hospital offers.

119. Since its inception in 1975, LRCC and its cardiologists had always been in-network with Blue Cross and all of its plans (including, significantly, the employer self-insured plans administered by Blue Cross, which are a large, if not majority, component of the private insurance in the market), and LRCC's member cardiologists continuously maintained clinical and staff privileges at Baptist Health. This changed in 1997.

120. Because the hospitals in the market were not responding to or keeping pace with the rapid technological changes in vascular medicine, and because cardiology patients were being deprived of certain procedures readily available in other parts of the country, in or about 1995, LRCC and certain of its member physicians, began planning to develop a specialty hospital in Little Rock (ultimately named Arkansas Heart Hospital), which would specialize in cardiology services and would compete directly with Baptist Health in offering hospital services for cardiology patients.

121. When the President of Baptist Health, Russ Harrington, learned of those plans, he contacted Dr. Bruce Murphy, one of the principal LRCC doctors involved in the planning and implementation of the proposed heart specialty hospital, tried to dissuade Dr. Murphy from proceeding, and warned him that if he proceeded, Dr. Murphy could be damaged personally.

122. During that meeting, which included Mr. Harrington and Larry Lazenby from Baptist Health, Mr. Harrington said about the planned Heart Hospital: "Our Board met Tuesday, and they're very concerned about it. They don't think it's good for this community and they – we had trouble giving them any insight into why any physicians in the area would want to join up with a for-profit company who have never run a hospital before would come and build one in Little Rock, Arkansas."

123. Dr. Murphy stated that "this is not going to affect Baptist Hospital in any meaningful way. I mean, we're not moving. Little Rock Cardiology Clinic is not moving their practice from Baptist. We are not moving from St. Vincent's. We believe that patients should have the freedom of choice and are going to do it differently."

124. Mr. Harrington admitted that "we are not fearful that it's going to impact us greatly." The two then discussed the fact that there was an over-supply of general hospital beds in the market.

125. Mr. Harrington stated: "And we don't believe that carve-out or specialty hospitals will survive the long-term with the way reimbursement goes."

126. Dr. Murphy explained that his practice was evolving toward procedures and methods that shortened hospital stays, which would decrease the need for beds in general hospitals in the market. He also explained his concern that managed care might limit necessary and desirable cardiology procedures for patients, citing an example from California. Dr. Murphy described the economic efficiencies of a specialty hospital as opposed to a general, acute hospital:

> I think that cardiologists and cardiovascular surgeons can make the right economic choices in the hospital and the efficiency choices in the hospital. And predominantly in an out-patient setting to make things more efficient. And I think that if they're incentivized to do so, that they will so whether that's in a stand-alone orthopedic facility, or stand-alone eye facility, or stand-alone heart facility. Are those, is that the future of medicine in America? And is the tertiary care hospital that is going to be relegated to take care of the sick and dying? That is the basic fundamental issue I think on the table. Is that how you perceive it?

127. In response, Mr. Harrington stated bluntly that specialty hospitals would be "cut out" of insurance networks and could not survive. He said:

> I think that it has to do with the definitions, but I think the future is a balance between the required level of acute facilities that you are going to have for very sick people and specialized centers of excellence that are tied to acute facilities. I do not believe that the stand-alone hospitals are going to survive. I don't think that they would survive because I think they will basically be cut out, completely cut out of the network by not only third party carriers, managed care

> companies, but also government because what payors and employers and managed care companies are looking for is basically one-stop shopping. They want a comprehensive unit, not a single purpose one. And I think in the long term, those facilities will not survive. Now, we may be talking five or ten years from now, but I think that is going to be a real mistake. I would never have built the eye centers someplace else. It had to be here on this campus tied to the acute facility.

128. Dr. Murphy responded that patients prefer specialty care to general, acute care hospitals: "Why do my patients have to go through all the misery of being admitted to a tertiary care hospital and all the trauma involved in that and the feeling that they are a hospitalized patient when they're not. And so that's one of our highly motivating factors."

129. Mr. Harrington ended the meeting with his warning that Dr. Murphy might be damaged personally.

> And we hate to see a blip out there that could have some damage either to us or to the community and so we're just very concerned about that. I mean, and I would tell you though we don't know each other well, I would also be concerned for you in that regard and you'd have to make up your own mind

about whether or not you ought to go forward with that.

130. On March 3, 1997, Arkansas Heart Hospital ("AHH") opened its doors and began providing medical care to patients. LRCC and its shareholder doctors became direct and indirect owners of AHH. The results for cardiac patient care have been extraordinary. Since its opening, and continuing to the present, AHH has consistently delivered services that have resulted in better outcomes – – shorter lengths of stay at lower costs, fewer infections and lower rates of complications, adverse outcomes and mortality than at any other hospital in Arkansas. Because some 95% of the cardiac procedures performed at AHH are performed by LRCC physicians, the results obtained at AHH are in effect the results obtained by plaintiffs, attributable to the exceptional skill and quality of plaintiffs' care.

131. At some time not currently known by plaintiffs, but beginning no later than early 1997 and continuing thereafter, Baptist Health, Blue Cross and HMO Partners acted in combination and in concert to protect Baptist Health from competition from AHH. Through their combination and concerted conduct, they committed the following anticompetitive acts, among others.

132. In about June of 1997, USAble, acting for Blue Cross, terminated its PPO network provider agreements with LRCC and its doctors, the plaintiff cardiologists. This termination was an action taken in concert and in combination with HMO Partners and Baptist Health to restrain and monopolize trade unlawfully, specifically to protect Baptist Health

from competition in the relevant market from AHH. By terminating LRCC and the plaintiff cardiologists from the PPO network, Blue Cross sought to deny plaintiffs the ability to treat privately insured cardiology patients on terms economical to the patients, knowing that this would cause the patients to seek other cardiologists and to terminate their relationships with or never choose the plaintiffs to provide cardiology services. Shutting off the plaintiffs' access to PPO patients was intended to foreclose any chance that the patients could obtain hospital services at AHH.

133. Even though AHH was out of network on the BCBS PPO plans, cutting the plaintiffs out of the PPO networks was designed to and did have the effect of making the plaintiffs themselves out of network to existing and potential patients, so that their existing and potential cardiology patients would have to overcome the additional barrier of out-of-network cardiologist expenses in order to receive treatment from the plaintiffs. The anticompetitive effect of this exclusion existed regardless of whether the patient would have chosen AHH, Baptist Health, or any other hospital. Thus the PPO network exclusion was broader than was necessary to achieve the unlawful purpose of protecting Baptist Health from hospital competition from AHH.

134. Further, excluding the plaintiffs from the PPO network had the additional consequence of steering the plaintiffs' existing and potential cardiology patients who were covered by the PPOs to cardiologists who remained in network and were therefore favored by the anticompetitive actions of BCBS, HMO Partners and Baptist Health.

135. As part of the combination and concerted action, in September 1997 HMO Partners terminated its HMO network provider agreements with LRCC and its doctors, the plaintiff cardiologists. This termination was an action taken in concert and in combination with BCBS and Baptist Health to restrain trade unlawfully, specifically to protect Baptist Health from competition in the relevant market from AHH. By terminating LRCC and the plaintiff cardiologists from the HMO network, HMO Partners sought to deny plaintiffs the ability to treat privately insured cardiology patients on terms economical to the patients, knowing that this would cause patients to seek other cardiologists and to terminate their relationships with or never choose the plaintiffs to provide cardiology services. Shutting off the plaintiffs' access to HMO patients was intended to foreclose any chance that the patients could obtain hospital services at AHH.

136. Even though AHH was out of network on the HMO plans, cutting the plaintiffs out of the HMO networks was designed to and did have the effect of making the plaintiffs themselves out of network, so that their existing and potential cardiology patients would have to overcome the additional barrier of out-of-network cardiologist expenses in order to receive treatment from the plaintiffs. The anticompetitive effect of this exclusion existed regardless of whether the patient would have chosen AHH, Baptist Health, or any other hospital. Thus the HMO network exclusion was broader than was necessary to achieve the unlawful purpose of protecting Baptist Health from hospital competition from AHH.

137. Further, excluding the plaintiffs from the HMO network had the additional consequence of steering the plaintiffs' existing and potential cardiology patients who were covered by the HMO to cardiologists who remained in network and were therefore favored by the anticompetitive actions of BCBS, HMO Partners and Baptist Health.

138. The termination of the provider agreements of LRCC and the plaintiff physicians had nothing to do with any legitimate or lawful interest of HMO Partners or BCBS. Before AHH arrived in the market, LRCC and the plaintiffs were active and valuable members of the PPO and HMO networks. There was no change in market dynamics, demand, the plaintiffs' medical abilities, or any feature of the market structure other than the opening of AHH to trigger the termination of these provider contracts.

139. On May 6, 1998, Health Advantage wrote to a list of primary care physicians in Arkansas concerning the exclusion of LRCC from the HMO networks and from the Blue Cross PPO networks. This letter, sent by Health Advantage for HMO Partners, USAble and BCBS, states that "We are still having a problem with physicians referring both Health Advantage and FirstSource [the PPO] members to this clinic [LRCC]. This is creating an undue burden for the members since their services are paid as an out-of-network expense. . . . We would appreciate your assistance in referring to cardiologists that are in our networks."

140. By disciplining primary care physicians for referring patients to the plaintiffs, HMO Partners, USAble and BCBS unnecessarily interfered with and destroyed the valuable referral networks that the plaintiffs had built over years with

primary care physicians. A cardiologist is a medical specialist whose primary source of business is referrals from other doctors, particularly from primary care physicians. After the plaintiffs were excluded from the defendants' networks and plans, and in view of the disciplining of primary care physicians that the defendants engaged in to ensure the plaintiffs would not obtain patients from the defendants' networks, the defendants destroyed the referral relationships that had existed with the primary care physicians. Primary care physicians for the most part were too busy to take the time to determine which patient could be referred to the plaintiffs, and they quickly developed new referral patterns with other cardiologists, those favored by defendants' anticompetitive conduct, that replaced those with the plaintiffs. This resulted in the loss of patients who would have chosen the plaintiffs for cardiology services if given the option.

141. Despite repeated requests thereafter by LRCC and its doctors to be let back into the networks, and despite numerous letters and cards from LRCC patients so requesting, BCBS and HMO Partners refused to budge from the exclusion.

142. When LRCC or any of its doctors sought reinstatement to the PPO and HMO networks, they were invariably told by BCBS and HMO Partners that they had no need for additional doctors in the networks, and reinstatement or admission was refused. But as soon as any LRCC doctors left LRCC, they were in fact immediately reinstated to in-network status in both the PPO and the HMO.

143. Similarly, when Dr. Paulo Ribeiro moved to Arkansas in 2001 to practice with a different cardiology group, he was accepted as an in-

network physician with BCBS and HMO Partners. At the end of that year he left Arkansas and moved away. In the latter part of 2002, Dr. Ribeiro returned to Arkansas to work as a physician with LRCC. This time, however, he was denied his prior in-network status, and to this day remains excluded from both BCBS and HMO Partners networks.

144. Similarly, Drs. DeBryun and Hatch worked with LRCC and were excluded as providers from defendants' managed care plans while affiliated with LRCC. However, when they left LRCC for other cardiology practices in the area, they were immediately permitted to become providers under these plans. There was no change in market conditions or the qualifications of these physicians to warrant this about-face by the defendants.

145. Because of defendants' dominance of the private insurance market for cardiology patients, as a consequence of being excluded from the BCBS and HMO Partners networks and plans, plaintiffs effectively were excluded from participating, let alone competing, in the market for privately insured cardiology patients. Plaintiffs were also denied the ability to continue to care for long-standing patients who were covered by these networks.

146. By late 2002, Baptist Health learned that certain neurosurgeons and orthopedists on staff at Baptist Health planned to form a specialty surgical hospital in the Little Rock area, referred to by Baptist Health as the "spine hospital". Upon learning of this proposed new hospital, which would compete with Baptist Health, Baptist Health worked in combination and concert with Blue Cross and HMO Partners to protect Baptist Health from competition from the spine hospital, actions which

spilled over to AHH and the plaintiffs. These actions resulted in the "Economic Credentialing Policy."

147. In late 2002, Baptist Health administration officials set about secretly researching the feasibility of implementing an economic credentialing policy at Baptist Health. This policy was not formed with the participation – or even the knowledge – of the medical staff of Baptist Health. In February of 2003, the Executive Committee of Baptist Health passed an Economic Credentialing Policy to prohibit any doctor from having or maintaining staff privileges at any Baptist Health facility if that doctor directly or indirectly held any interest in a "competing hospital." A "competing hospital" was defined as "any hospital in the state of Arkansas." The purpose of the policy was to stifle competition from specialty hospitals and thereby to protect Baptist Health and the alliance of Baptist Health, Blue Cross and HMO Partners. Indeed, the President of Baptist Health has admitted under oath that the primary purpose, and the only purpose he could think of, for the policy was to discourage specialty hospitals from entering the marketplace and to exclude them from it.

148. In the Minutes of the February 18, 2003, meeting of the Executive Committee, Doug Weeks of Baptist Health described the Economic Credentialing Policy in these words: "Physicians who invest in specialty hospitals such as the proposed North Little Rock spine hospital would not be allowed to join the staff at BAPTIST HEALTH." One advantage of the policy was "to show loyalty to doctors who are loyal to BAPTIST HEALTH."

149. The Minutes show that the Policy was adopted in concert with Blue Cross: "There should

also be reconfirmation with Blue Cross regarding no access to the network." On information and belief, the referenced network was FirstSource, which was necessary for continued PPO, HMO and self-insured-plan participation.

150. On information and belief, Baptist Health's "reconfirmation" of the network exclusion also took place with HMO Partners, or with BCBS on behalf of HMO Partners.

151. The Economic Credentialing Policy was adopted by the Baptist Health Board of Trustees in May of 2003.

152. The consequences of the Economic Credentialing Policy were potentially crippling to affected doctors, and were intended to be. Thus, before the institution of this policy, even though a doctor was not in network with Blue Cross or HMO Partners, he or she could nonetheless refer or treat a patient at Baptist Health facilities. This would permit the patient to receive in-network facility charges from the physician of the patient's choice. However, after a doctor's staff privileges were removed, that doctor could no longer admit or treat any patient at Baptist Health.

153. This exclusion would interfere with existing and future doctor-patient relationships and cause the loss of patient referrals to specialists, including the plaintiffs, from primary care doctors around the state. The referral problem was exacerbated because Baptist Health had purchased many primary-care physician practices over the years.

154. In February of 2004, the plaintiff cardiologists, other than Dr. Ribeiro, filed a lawsuit in Arkansas state court that sought to enjoin the

enforcement of that Policy. On or about February 26, 2004, they obtained a temporary injunction against its enforcement against them, and the injunction has remained in effect up to the time of the filing of this complaint.

155. In 2003 LRCC opened its cath lab. The cath lab provides diagnostic and peripheral interventional services to cardiology patients, in direct competition with Little Rock hospitals, including both AHH and Baptist Health. The services provided by LRCC's cath lab meet and exceed the quality of services provided by similar labs in hospitals in Little Rock.

156. LRCC's cath lab is the only cath lab in Arkansas that is not physically attached to a hospital.

157. In every state surrounding Arkansas, Blue Cross entities reimburse stand-alone cath labs like LRCC's for their facility charges,

158. Medicare, Medicaid and several private insurers reimburse LRCC's cath lab for facilities services according to the same terms as they reimburse similar labs in hospitals (although at lower rates).

159. However, as part of the contract, combination, conspiracy and concerted action against LRCC, BCBS and HMO Partners have excluded the LRCC cath lab from reimbursement for facility charges. BCBS and HMO Partners reimburse similar cath labs in hospitals in Arkansas for identical procedures. On information and belief, BCBS and HMO reimburse stand-alone clinics and labs across Arkansas for their facility charges.

160. On information and belief, the refusal of HMO Partners and BCBS to reimburse LRCC for

procedures in its cath lab is an action taken by them through and as part of the contract, combination, conspiracy and concerted action of the defendants alleged in this complaint.

161. On December 10, 2003, USAble terminated an El Dorado cardiologist, Dr. Fonticiella, from the FirstSource network for referring patients to Arkansas Heart Hospital, which was excluded from the FirstSource network. Dr. Fonticiella had explained that he referred six cardiology patients to AHH because Baptist Health was on diversion, meaning Baptist Health had no room for any more cardiology patients to be admitted. USAble terminated Dr. Fonticiella because "the diversion could not be confirmed in four of the cases."

162. On the same day, HMO Partners, acting as Health Advantage, notified Dr. Fonticiella that Health Advantage "has received information from USAble Corporation, that your participation in Arkansas' FirstSource PPO network will be terminated . . .. Participation in the Health Advantage network is contingent upon continued participation in FirstSource. Accordingly, we will terminate your Health Advantage participation . . .."

163. Defendants marketed their PPO products as having out-of-network benefits. They did so in order to convince employers and their employees that patients could choose out-of-network hospitals and physicians instead of those contained in the FirstSource network. This was a valuable marketing ploy, because patients and employers prefer choice of health care providers. However, at least with respect to the cardiology services at issue in this case, this insurance marketing was false and

deceptive, because the defendants actively policed their networks and disciplined primary care physicians for referring cardiology patients out of network.

164. From the time of the passage of the Patient Protection Act of 1995, known as the "Any Willing Provider" statute, until late 2005, Blue Cross and HMO Partners refused to comply with the statute's provisions and refused to let plaintiffs back into network even though plaintiffs were willing to abide by Blue Cross and HMO Partners' terms and conditions. When decisions by the federal courts made continuation of that conduct impossible, beginning in the latter part of 2005, defendants were forced to allow hospitals and doctors into network. By January of 2006, all of the LRCC doctors were allowed back into network with BCBS and HMO Partners. None of them, however, was placed into FirstSource or any network used by employer self-insured plans (which, prior to its expulsion of LRCC and its doctors in 1997, they had been). Thus, for the roughly 50% of the privately insureds in Arkansas who are covered by employer self-insurance programs, LRCC and its doctors remain out of network.

165. The refusal of BCBS and HMO Partners to reimburse LRCC's cath lab for any procedures, regardless of whether the procedures are for patients covered by managed care plans subject to the Patient Protection Act of 1995 or are ERISA self-insured plans, violates the Patient Protection Act of 1995.

HARMFUL EFFECTS ON COMPETITION HOSPITAL MARKET

166. Injury to competition occurs when price is higher or the quality lower than would be the case in a competitive market. Plaintiffs have MEDPAR data on the quality of hospital cardiology and cardiac surgery services for Baptist-Little Rock, AHH and other Arkansas hospitals. These show that, for Medicare patients, in 5 of 6 cardiology procedures, mortality, complication rates and length of stay are far lower at AHH than at Baptist-Little Rock. In fact, the data show that mortality and adverse outcomes occur with more frequency at Baptist-Little Rock than they do on average in Arkansas hospitals for several procedures.[8] For a patient with congestive heart failure, all else being equal, the chance of death or other adverse outcome within 30 days of being admitted to the hospital is 35% higher at Baptist-Little Rock than at AHH. For patients with acute myocardial infarction, the odds of death are 50% greater at Baptist-Little Rock than at AHH, and the odds of adverse outcome are 33% greater. For patients who receive percutaneous coronary intervention, the chance of death is 50% higher at Baptist-Little Rock than at AHH. See attached Exhibit D.

167. This analysis implies that the absence of competition in the private-insurance cardiology market at issue has resulted in lower quality cardiology services at Baptist-Little Rock than at Arkansas hospitals generally and AHH specifically.

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[8] See the document attached and incorporated herein by reference as Exhibit D to this complaint.

168. Plaintiffs have also reviewed cost information based on Arkansas Department of Health discharge and pricing statistical data available at www.hospitalconsumerassist.com.[9] For the five hospitals in the Little Rock private-insurance cardiology market, these data include 12 DRGs for hospital-based cardiology procedures. See attached Exhibit A. Of these 12 DRGs, one hospital, Southwest Regional, has no discharges for 7 of the DRGs. Of the 9,164 discharges in the 12 DRGs, Southwest Regional has 79 total discharges for the 5 DRGs for which it reports discharges. The four other hospitals are St. Vincent's, AHH, Baptist-Little Rock and Baptist-North Little Rock.

169. The total discharges and rounded percentages are:

St. Vincent's:	1,924	(21%)
AHH:	2,920	(32%)
Baptist-LR:	2,697	(29%)
Baptist-NLR:	1,545	(17%)
Southwest:	79	(.8%)
Baptist Health:	4,242	(46%)

170. The price information shows that AHH is the lowest-cost provider in 10 of the 12 DRGs, based on average cost. In the remaining 2 DRGs, St. Vincent's has the lowest average cost in one (DRG 515) and Baptist-North Little Rock has the lowest cost in one (DRG 125). On information and belief, these data include statistics from both Medicare and private insurance.

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[9] Attached as and incorporated by reference as Exhibit E.

171. Thus AHH is the lowest-cost provider in the market for hospital services for cardiology patients. Society would benefit from competition between AHH and Baptist Health for insurance patients, because the net costs would decrease.

172. This evidences injury to competition on both price and quality in the hospital market for cardiology services in Little Rock.

173. Baptist Health is the dominant hospital in the market, and its prices are higher than would exist in a competitive market where Baptist Health had to meet a price set by the market.

INSURANCE MARKET

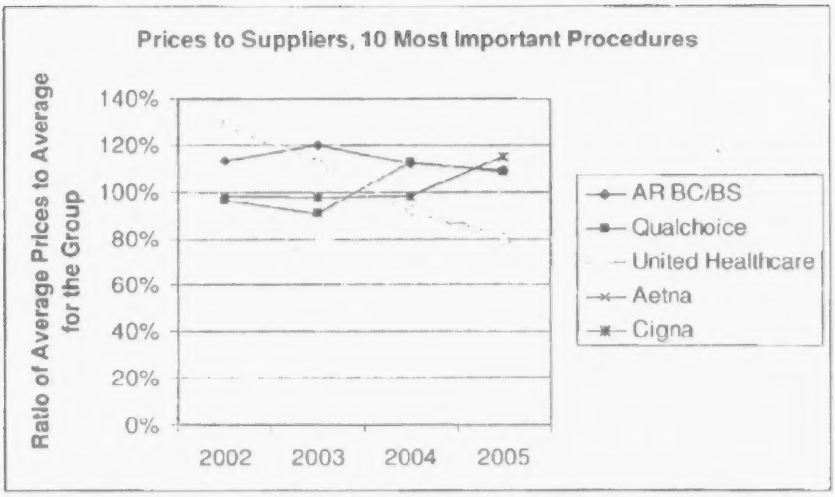
174. Available pricing data show that BCBS insurance premiums and amounts paid for health care have exceeded those charged by the other insurers in the Arkansas market and by the BCBS peer group in surrounding states.

175. From 2002 to 2005, BCBS paid consistently higher prices than other Arkansas insurers to providers for the ten most frequent cardiology procedures. Figure 1 shows that in this period, a simple average of the prices that BCBS paid for these procedures is consistently higher those paid by its competitors. The Blue Cross prices were 17%, 26%, 16% and 11% higher than the averages for the group in 2002 through 2005 respectively.[10]

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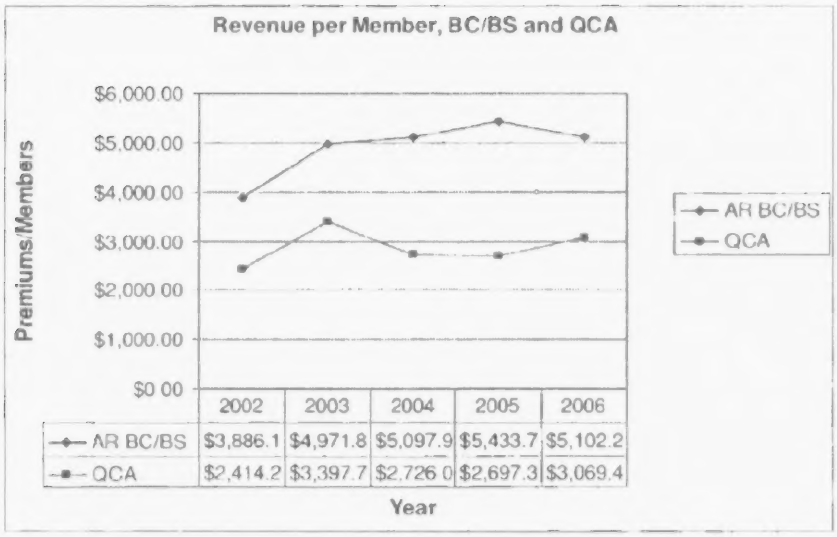
[10] In order to secure providers for its network, United HealthCare paid "list price" when it entered the market in 2002, but it reduced payments over the next years. This effort by United HealthCare to buy provider relationships is the only time in which the BCBS reimbursements were not above all others in the market.

FIGURE 1



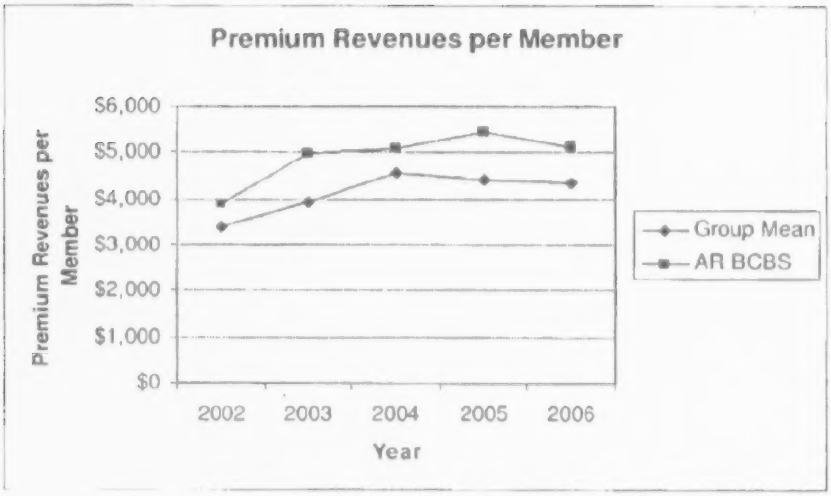
176. BCBS's financial statements show that, as well as paying its suppliers more than its competitors paid, its overall prices to customers were higher. The evidence on insurance prices is summarized in Figure 2 below. Within Arkansas, BCBS primarily competed with United Healthcare and QualChoice. Arkansas figures for United Healthcare are not available, but plaintiffs can compare BCBS with Qualchoice. Figure 2 shows that BCBS's revenue per insured exceeded considerably Qualchoice's revenue per insured in every year from 2002-2006. On average Blue Cross received 70% more per member than QCA over this period.

FIGURE 2



177. BCBS's revenue per member is also higher than the average of a cohort of insurers active in the Southern United States. Figure 3 shows BCBS's revenue per member compared with the averages of the group, which includes Aetna U.S. Healthcare Group, CIGNA, Community Care HMO, Coventry Health Care, Cox Health Systems HMO, Health Care Service Corp, Health Plus of Louisiana, Heartland Health, Humana, Mercy Health Plans, QCA Health Plan, UnitedHealth Group Incorporated, and Wellpoint Inc.

FIGURE 3



178. The effect of these higher prices is that BCBS's profits were consistently higher than its peers. This is shown in Figures 4, 5 and 6 below. Figure 4 shows that BCBS had consistently higher profits per member than Qualchoice, while Figures 5 and 6 shows that BCBS's profits per member and profit margins (profits per dollar of revenue) consistently exceeded those of other BC/BS systems in the South:

FIGURE 4

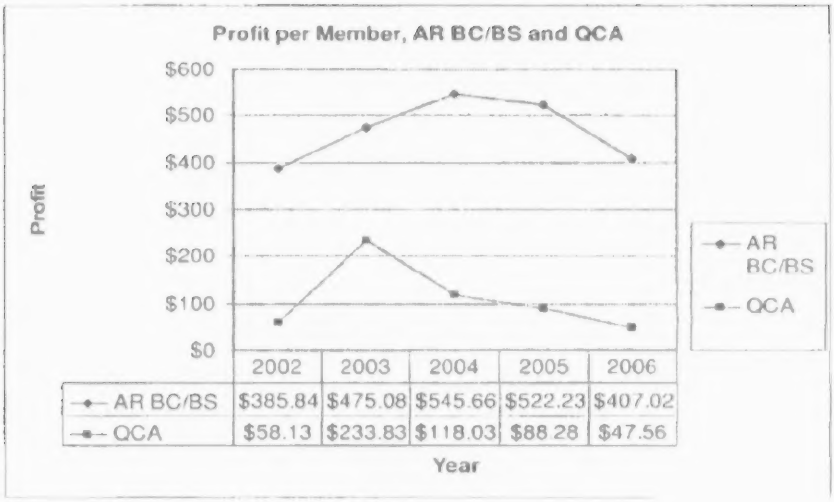


FIGURE 5

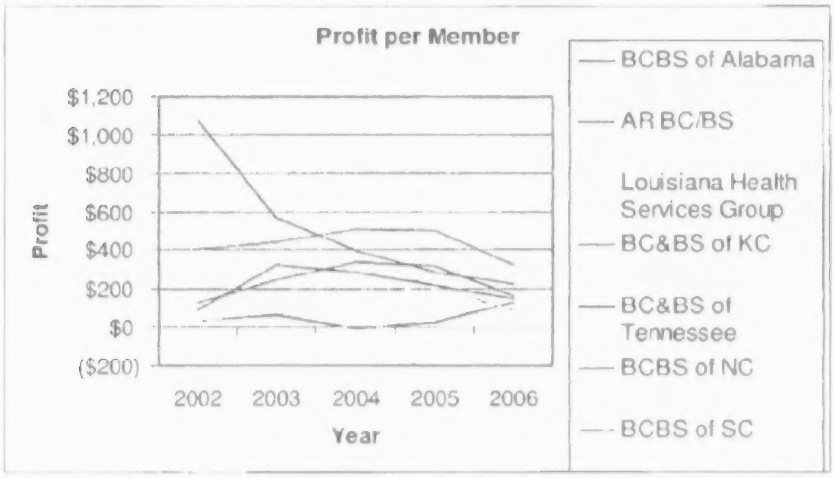
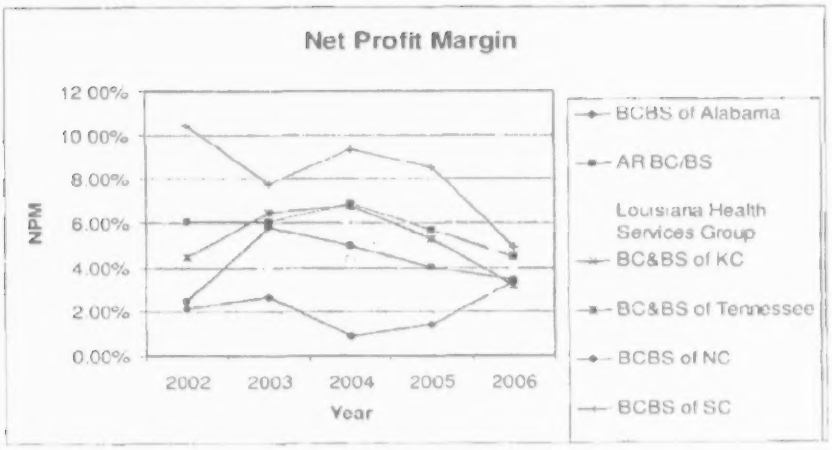


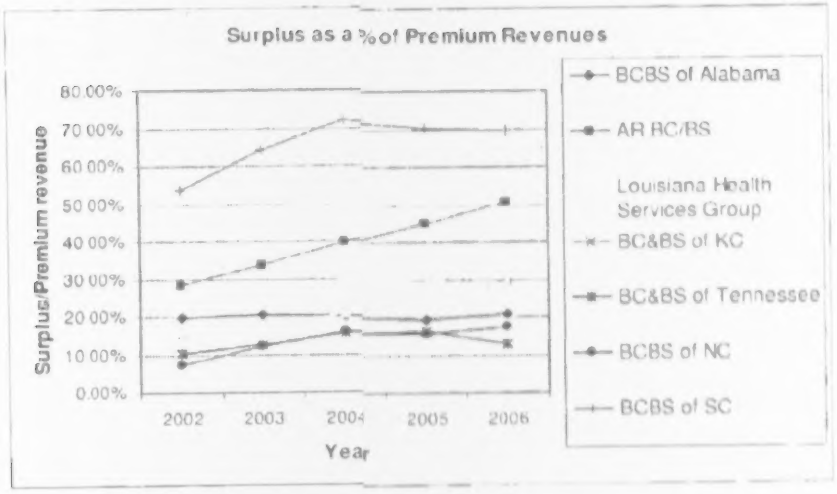
FIGURE 6



179. Another indicator of BCBS's consistently higher profitability than other BC/BS systems in the region is that it maintained a consistently higher surplus ratio (surplus per dollar of premiums).[11] This is illustrated in Figure 7.

[11] Surplus ratio is the ratio of an insurer's retained earnings to annual premium income. The rule of thumb in the insurance industry is that surplus should equal no less than 5% and no more than 25% of premium income.

FIGURE 7


Surplus as a % of Premium Revenues
Surplus/Premium revenue
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
2002
2003
2004
2005
2006
Year
BCBS of Alabama
AR BC/BS
Louisiana Health Services Group
BC&BS of KC
BC&BS of Tennessee
BCBS of NC
BCBS of SC

180. Finally, the available data show that BCBS paid more than its competitors did for health-care services. This is shown in Figure 8, which shows that BCBS's expenses per insured have consistently exceeded those of Qualchoice, and Figure 9, which shows BCBS's expenses have consistently exceeded those of the group of peer insurers active in the South.

FIGURE 8

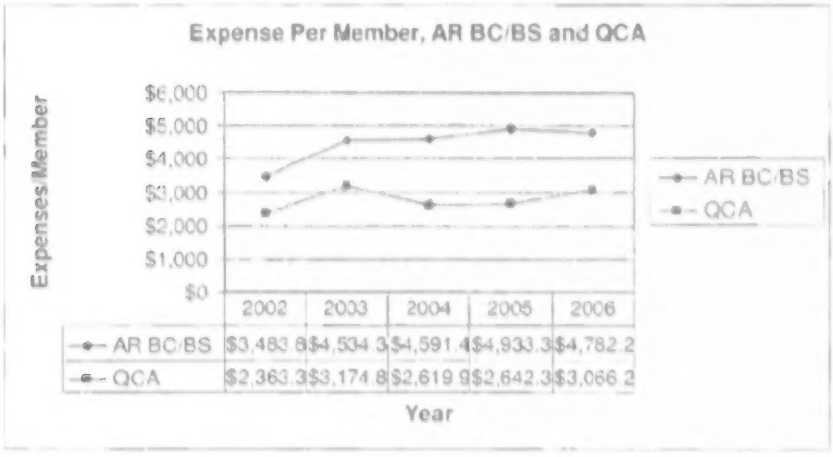
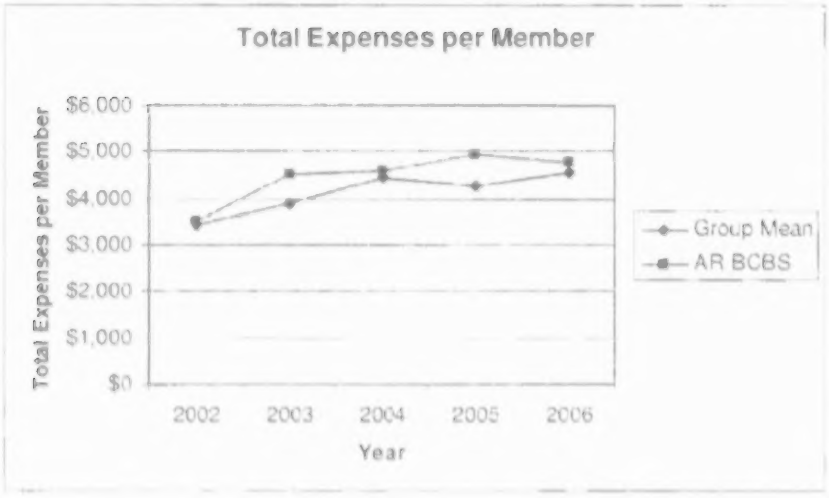


FIGURE 9



181. In summary, BCBS pays more than Qualchoice for medical services and overhead in Arkansas and adds a higher profit markup to those costs. This results in substantially higher charges per insured for BCBS than for Qualchoice in Arkansas and a cohort of the regional peers of BCBS in surrounding states.

182. The ability of BCBS to extract higher premiums is an expected consequence of the monopoly power consistently maintained by BCBS in the market for private health insurance in Arkansas from at least 2002 through 2006.

183. That BCBS pays higher prices to Baptist Health as its exclusive hospital partner in the relevant market is contrary to the efficiencies and resulting lower costs that would be expected from the arrangement in a competitive market. If the exclusive arrangement resulted in efficiencies,

then BCBS's costs and premium prices would not be higher than its peers.

184. In the absence of the barriers to entry that exist in the relevant market, hospital competitors of Baptist Health would offer lower prices to BCBS to obtain a network relationship with BCBS. Similarly, in a competitive market and absent barriers to entry, insurance competitors would enter the market and offer lower premiums. Neither of these occur in the relevant market because of barriers to entry presented to competitors by virtue of the Baptist Health/Blue Cross/HMO Partners combination and concerted action.

185. The defendants' market power, exclusive-dealing arrangements and monopoly positions in the market have enabled them to charge supracompetitive prices, reap monopoly profits, favor suppliers with higher health-care reimbursements, maintain market dominance and deter entry of new competitors. As a consequence of this actual monopolization, BCBS, in concert with all of the defendants, has stifled competition in the market for private health insurance.

186. The exclusive contracts between Baptist Health and BCBS and HMO Partners for the insurance contracts transfer the monopoly power of the defendants in the insurance market into the hospital market for cardiology services for privately insured patients.

Health Insurer Market Concentration

187. The American Medical Association tracks market concentrations in health insurance and has published its most recent report entitled, "Competition in health insurance: A comprehensive study of U.S. markets/2007 update." This update is based on HMO and PPO enrollment data as of January 1, 2005, compiled by InterStudy's Managed Market MSA Surveyor and Managed Market State Surveyor. These data are used to compute the Herfindahl-Hirshman Index ("HHI") of competition in a market. The markets are based on metropolitan statistical areas ("MSA"), and the data for the Little Rock market therefore has a broader geographic footprint than the geographic market at issue here. However, on information and belief, the data for the relevant geographic market mirror the MSA-based data for Little Rock.

188. The American Medical Association is an authoritative source of market information in the health care industry, and the HHI is the legally authoritative measure of market concentration for purpose of antitrust analysis of proposed mergers or acquisitions.

189. Under the HHI, a value in excess of 1,800 indicates a highly concentrated market. In the Little Rock MSA, the HHI for the combined PPO and HMO market shares is 6,021, with Blue Cross having 77% market share and United Healthcare having 9%.

190. The AMA observes that, "While large health insurers have posted very healthy profits since 2000, premiums for consumers have increased without a corresponding increase in benefits. In fact,

. . . consumers have faced increased deductibles, co-payments and co-insurance [which] has effectively reduced the scope of their health benefits coverage." Page 2. The report concludes that physicians lack bargaining power to negotiate contracting terms and reimbursement rates with dominant health insurers, which are those with at least 30% market share. *Id.*

191. The AMA also identifies barriers to entry in the health insurance field, such as "state regulatory requirements, the cost of developing a provider network, and the development of sufficient business to permit the spreading of risk. If entry into health insurance markets were easy, one would expect to see significant entry in response to the significant profits many health insurers have posted in the past five years. However, the opposite has occurred." *Id.*

192. As a direct result of this combination and conspiracy, interstate commerce has been restrained, competition in the market has been harmed, and plaintiffs have suffered and continue to suffer antitrust injury from being excluded and restrained from competing for cardiology patients. Their damages include lost revenues in the millions of dollars that they would have obtained had there been competition in this market.

193. One specific consequence of the defendants' restraint of trade and monopolization was a change in the plaintiffs' payor mix to a higher percentage of Medicare and Medicaid patients than would have obtained in a competitive market, which resulted in substantial lost revenues to the plaintiffs.

COUNT I

(Section 1 Contract, Combination and Conspiracy in Restraint of Trade)

194. Plaintiffs incorporate by reference all of the foregoing allegations of paragraphs 1-193 of this complaint, as well as the exhibits to this complaint.

195. The defendants' conduct specifically alleged in this complaint constitutes an unlawful contract, combination, concerted action or conspiracy to exclude competition and unreasonably restrain interstate commerce in violation of Section 1 of the Sherman Act (15 U.S.C.§ 1). The defendants' conduct is not honestly industrial and is not competition on the merits. To the contrary, the success of defendants' conduct depends on successful restraint of competition.

196. Through their unlawful contract, combination, concerted actions and conspiracy, the defendants have engaged in the alleged anticompetitive conduct for the purpose of restraining commerce in the market for hospital services for cardiology patients covered by private insurance. The defendants were motivated to erect barriers to entry in order to protect their monopoly positions and market power: the hospital monopoly required the active support, combination and concerted action of BCBS and HMO Partners, and the private-insurance monopoly required the active support, combination and concerted action of Baptist Health.

197. Through their unlawful contract, combination, concerted action and conspiracy, the defendants have unlawfully injured competition in

and adversely affected interstate commerce and business activities in interstate commerce, by, among the other things alleged in this complaint, unreasonably raising prices, restricting patient choice of doctors and hospitals, excluding competition from other hospitals and insurers, raising and maintaining barriers to entry, and harming patient health.

198. Through their unlawful contract, combination, concerted action and conspiracy, the defendants have proximately caused antitrust injury to plaintiffs by excluding and restraining plaintiffs from competing for privately insured cardiology patients, including the loss of referrals for potential patients and the breaking of long-established patient-physician relationships. The interference with plaintiffs' physician-referral network extended beyond the loss of referrals of privately-insured patients and also resulted in the loss of non-insured patient referrals from the formerly referring physicians. As a direct result of defendants' anticompetitive actions, plaintiffs have suffered damages to their property, trade and business in an amount in the millions of dollars, to be established at trial.

199. Plaintiffs are entitled to their actual damages, trebled, plus reasonable attorneys' fees and costs, under Section 4 of the Clayton Act, 15 U.S.C. §15.

COUNT II

(Conspiracy to Monopolize – Cardiology Procedures)

200. Plaintiffs incorporate by reference all of the foregoing allegations of paragraphs 1-199 of this complaint, as well as the exhibits to this complaint.

201. As specifically alleged in this complaint, defendants have combined and conspired to monopolize the market for hospital services for privately insured cardiology patients in violation of Section 2 of the Sherman Act (15 U.S.C. §2). The defendants' conduct is not honestly industrial and is not competition on the merits. To the contrary, the success of defendants' conduct depends on successful restraint of competition.

202. Through their unlawful combination and conspiracy to monopolize the market, defendants have engaged in the overt acts, including but not limited to the network exclusions and the Economic Credentialing Policy, alleged above. The defendants were motivated to erect barriers to entry in order to protect their monopoly positions and market power: the hospital monopoly required the active agreement, support, combination and concerted action of BCBS and HMO Partners, and the private-insurance monopoly required the active agreement, support, combination and concerted action of Baptist Health.

203. Defendants each willfully engaged in the combination, conspiracy and overt acts that violated Section 2 of the Sherman Act (15 U.S.C. §2) and specifically intended to monopolize the market.

204. Through their unlawful combination and conspiracy, defendants have unlawfully injured competition in and adversely affected interstate commerce and business activities in interstate commerce.

205. Through their unlawful combination and conspiracy, defendants have excluded and restrained competition for hospital services for cardiology patients in the market, jeopardized the health of patients, lowered the quality of care available to cardiology patients in the market, erected and maintained barriers to competition for hospital services and private insurance for cardiology patients in the market, stifled innovation in the market, and increased prices for hospital services and private insurance in the market.

206. Through their unlawful combination and conspiracy, defendants have proximately caused antitrust injury to plaintiffs by excluding and restraining plaintiffs from competing for privately insured cardiology patients, including the loss of referrals for potential patients and the breaking of long-established patient-physician relationships. The interference with plaintiffs' physician-referral network extended beyond the loss of referrals of privately insured patients and also resulted in the loss of non-insured patient referrals from the formerly referring physicians. As a direct result of defendants' anticompetitive actions, plaintiffs have suffered damages to their property, trade and business in an amount in the millions of dollars, to be established at trial.

207. Plaintiffs are entitled to actual damages, trebled, plus reasonable attorneys' fees and

costs, under Section 4 of the Clayton Act, 15 U.S.C. §15.

COUNT III

(Attempt to Monopolize – Cardiology Procedures)

208. Plaintiffs incorporate by reference all of the foregoing allegations of paragraphs 1-207 of this complaint, as well as the exhibits to this complaint.

209. As specifically alleged in this complaint, defendants have attempted to monopolize the market for hospital services for privately insured cardiology patients in violation of Section 2 of the Sherman Act (15 U.S.C. §2). The defendants' conduct is not honestly industrial and is not competition on the merits. To the contrary, the success of defendants' conduct depends on successful restraint of competition.

210. In their attempt to monopolize this market, defendants have engaged in the unlawful contract, combination, conspiracy, overt acts and concerted actions specifically alleged in this complaint. The defendants were motivated to erect barriers to entry in order to protect their monopoly positions and market power: the hospital monopoly required the active agreement, support, combination and concerted action of BCBS and HMO Partners, and the private-insurance monopoly required the active agreement, support, combination and concerted action of Baptist Health.

211. Defendants' actions are anticompetitive and were undertaken with the specific intent to exclude and restrain competition, to control prices,

and to obtain a monopoly in the market for hospital services for privately insured cardiology patients.

212. There is a dangerous probability that defendants will succeed in their attempt to monopolize the market for hospital services for cardiology patients.

213. Defendants' attempt to monopolize this market has proximately caused antitrust injury to plaintiffs by excluding and restraining plaintiffs from competing for privately insured cardiology patients, including the loss of referrals for potential patients and the breaking of long-established patient-physician relationships. The interference with plaintiffs' physician-referral network extended beyond the loss of referrals of privately insured patients and also resulted in the loss of non-insured patient referrals from the formerly referring physicians. As a direct result of defendants' anticompetitive actions, plaintiffs have suffered damages to their property, trade and business in an amount in the millions of dollars, to be established at trial.

214. Plaintiffs are entitled to their actual damages, trebled, plus attorneys' fees and costs, under 15 U.S.C. §15.

COUNT IV

(Monopolization – Cardiology Procedures)

215. Plaintiffs incorporate by reference all of the foregoing allegations of paragraphs 1-214 of this complaint, as well as the exhibits to this complaint.

216. Baptist Health has and continues to possess monopoly power in the market for hospital services for privately insured cardiology patients.

217. Baptist Health obtained and maintained its monopoly power in this market by willful and unlawful acquisition through, among other anticompetitive conduct, the unlawful contract, combination, concerted action and conspiracy with the defendants specifically alleged in this complaint. The defendants' conduct is not honestly industrial and is not competition on the merits. To the contrary, the success of defendants' conduct depends on successful restraint of competition.

218. Through its unlawful monopoly, Baptist Health has excluded and restrained competition for hospital services for cardiology patients in the market, jeopardized the health of patients, lowered the quality of care available to cardiology patients in the market, erected and maintained barriers to competition for hospital services and private insurance for cardiology patients in the market, stifled innovation in the market, and increased prices for hospital services and private insurance in the market.

219. Through its unlawful monopoly, Baptist Health has proximately caused antitrust injury to plaintiffs by excluding and restraining plaintiffs from competing for privately insured cardiology patients, including the loss of referrals for potential patients and the breaking of long-established patient-physician relationships. The interference with plaintiffs' physician-referral network extended beyond the loss of referrals of privately insured patients and also resulted in the loss of non-insured patient referrals from the formerly referring

physicians. As a direct result of Baptist Health's anticompetitive actions, plaintiffs have suffered damages to their property, trade and business in an amount in the millions of dollars, to be established at trial.

220. Plaintiffs are entitled to actual damages, trebled, plus attorneys' fees and costs, under 15 U.S.C. §15.

COUNT V

(Conspiracy to Monopolize – Insurance)

221. Plaintiffs incorporate by reference all of the foregoing allegations of paragraphs 1-220 of this complaint, as well as the exhibits to this complaint.

222. As specifically alleged in this complaint, defendants have combined and conspired to monopolize the market for private insurance in violation of Section 2 of the Sherman Act (15 U.S.C. §2). This includes both HMO and PPO insurance. The defendants' conduct is not honestly industrial and is not competition on the merits. To the contrary, the success of defendants' conduct depends on successful restraint of competition.

223. Through their unlawful combination and conspiracy to monopolize the market, defendants have engaged in the overt acts, including but not limited to the network exclusions and the Economic Credentialing Policy, alleged above. The defendants were motivated to erect barriers to entry in order to protect their monopoly positions and market power: the hospital monopoly required the active agreement, support, combination and concerted action of BCBS and HMO Partners, and

the private-insurance monopoly required the active agreement, support, combination and concerted action of Baptist Health.

224. Defendants each willfully engaged in the combination, conspiracy and overt acts that violated Section 2 of the Sherman Act (15 U.S.C. §2) and specifically intended to monopolize the market.

225. Through their unlawful combination and conspiracy, defendants have unlawfully injured competition in and adversely affected interstate commerce and business activities in interstate commerce.

226. Through their unlawful combination and conspiracy, defendants have excluded and restrained competition for private insurance cardiology patients in the market, jeopardized the health of patients, lowered the quality of care available to cardiology patients in the market, erected and maintained barriers to competition for hospital services and private insurance for cardiology patients in the market, stifled innovation in the market, and increased prices for hospital services and private insurance in the market.

227. Through their unlawful combination and conspiracy, defendants have proximately caused antitrust injury to plaintiffs by excluding and restraining plaintiffs from competing for privately insured cardiology patients, including the loss of referrals for potential patients and the breaking of long-established patient-physician relationships. The interference with plaintiffs' physician-referral network extended beyond the loss of referrals of privately insured patients and also resulted in the loss of non-insured patient referrals from the formerly referring physicians. As a direct result of

defendants' anticompetitive actions, plaintiffs have suffered damages to their property, trade and business in an amount in the millions of dollars, to be established at trial.

228. Plaintiffs are entitled to actual damages, trebled, plus reasonable attorneys' fees and costs, under Section 4 of the Clayton Act, 15 U.S.C. §15.

COUNT VI

(Attempt to Monopolize – Insurance)

229. Plaintiffs incorporate by reference all of the foregoing allegations of paragraphs 1-228 of this complaint, as well as the exhibits to this complaint.

230. As specifically alleged in this complaint, defendants have attempted to monopolize the market for private insurance (both HMO and PPO) in violation of Section 2 of the Sherman Act (15 U.S.C. §2). The defendants' conduct is not honestly industrial and is not competition on the merits. To the contrary, the success of defendants' conduct depends on successful restraint of competition.

231. In their attempt to monopolize this market, defendants have engaged in the unlawful contract, combination, conspiracy, overt acts and concerted actions specifically alleged in this complaint. The defendants were motivated to erect barriers to entry in order to protect their monopoly positions and market power: the hospital monopoly required the active agreement, support, combination and concerted action of BCBS and HMO Partners, and the private-insurance monopoly required the

active agreement, support, combination and concerted action of Baptist Health.

232. Defendants' actions are anticompetitive and were undertaken with the specific intent to exclude and restrain competition, to control prices, and to obtain a monopoly in the market for private insurance for cardiology patients.

233. There is a dangerous probability that defendants will succeed in their attempt to monopolize the market for private insurance for cardiology patients.

234. Defendants' attempt to monopolize this market has proximately caused antitrust injury to plaintiffs by excluding and restraining plaintiffs from competing for privately insured cardiology patients, including the loss of referrals for potential patients and the breaking of long-established patient-physician relationships. The interference with plaintiffs' physician-referral network extended beyond the loss of referrals of privately insured patients and also resulted in the loss of non-insured patient referrals from the formerly referring physicians. As a direct result of defendants' anticompetitive actions, plaintiffs have suffered damages to their property, trade and business in an amount in the millions of dollars, to be established at trial.

235. Plaintiffs are entitled to their actual damages, trebled, plus attorneys' fees and costs, under 15 U.S.C. §15.

COUNT VII

(Monopolization – Insurance)

236. Plaintiffs incorporate by reference all of the foregoing allegations of paragraphs 1-235 of this complaint, as well as the exhibits to this complaint.

237. BCBS, directly and through its subsidiary USAble Corporation, and HMO Partners have and continue to possess monopoly power in the market for private insurance, including both HMO and PPO. These defendants' conduct is not honestly industrial and is not competition on the merits. To the contrary, the success of these defendants' conduct depends on successful restraint of competition.

238. These defendants obtained and maintained their monopoly power in this market by willful and unlawful acquisition through, among other anticompetitive conduct, the unlawful contract, combination, concerted action and conspiracy specifically alleged in this complaint.

239. Through their unlawful monopoly, these defendants have excluded and restrained competition for private insurance for cardiology patients in the market, jeopardized the health of patients, lowered the quality of care available to cardiology patients in the market, erected and maintained barriers to competition for hospital services and private insurance for cardiology patients in the market, stifled innovation in the market, and increased prices for hospital services and private insurance in the market.

240. Through their unlawful monopoly, these defendants have proximately caused antitrust injury

to plaintiffs by excluding and restraining plaintiffs from competing for privately insured cardiology patients, including the loss of referrals for potential patients and the breaking of long-established patient-physician relationships. The interference with plaintiffs' physician-referral network extended beyond the loss of referrals of privately insured patients and also resulted in the loss of non-insured patient referrals from the formerly referring physicians. As a direct result of these defendants' anticompetitive actions, plaintiffs have suffered damages to their property, trade and business in an amount in the millions of dollars, to be established at trial.

241. Plaintiffs are entitled to actual damages, trebled, plus attorneys' fees and costs, under 15 U.S.C. §15.

COUNT VIII

(Injunctive Relief)

242. Plaintiffs incorporate by reference all of the foregoing allegations of paragraphs 1-241 of this complaint, as well as the exhibits to this complaint.

243. Baptist Health, directly and through its subsidiary Baptist Medical System HMO Inc., BCBS, directly and through its subsidiary USAble Corporation, and HMO Partners have violated Section 1 of the Sherman Act through their combination, contract, conspiracy and actions in concert to restrain trade. These defendants have also conspired to monopolize, attempted to monopolize and actually monopolized the market for hospital services for cardiology patients covered by

private insurance and the market for private health insurance, in violation of Section 2 of the Sherman Act.

244. Among other unlawful anti-competitive acts, defendants continue to exclude plaintiffs from the markets for privately-insured patients who are covered by employer self-insurance plans of BCBS, USAble and HMO Partners. In addition, BCBS, USAble and HMO Partners unlawfully exclude LRCC's cath lab from reimbursement of facility charges.

245. Plaintiffs have suffered irreparable harm from these unlawful exclusions and will continue to suffer irreparable harm unless and until defendants are enjoined to cease and desist from these unlawful actions.

246. Plaintiffs have no adequate remedy at law to remedy future damages that will flow from defendants' continued unlawful exclusion of the plaintiffs from the self-insured plans of the defendants and from reimbursement for the facility charges of the LRCC cath lab.

247. The Court should enter permanent injunctive relief enjoining and compelling the defendants to admit plaintiffs to their plans for self-insured employers and to reimburse the LRCC cath lab on the same terms as they reimburse hospitals that provide the same services.

JURY DEMAND

Plaintiffs demand a trial by jury of all issues so triable.

WHEREFORE, plaintiffs demand judgment jointly and severally against the defendants on all Counts, except severally against Baptist Health on the claims in Count IV, for their actual damages proximately caused by the defendants, trebled as required by law, permanent injunctive relief as requested in Count VIII, for their expenses, costs, attorneys' fees and all other just and proper relief.

EXHIBIT A TO PETITIONERS' THIRD AMENDED COMPLAINT

Health System Change in Little Rock, Ark.

Loel Solomon, Robin K. Omata*, Robert F. St. Peter+*
**The Lewin Group*
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Little Rock is on the brink of significant health system change. While established insurers and providers are looking for new ways to control health care costs, national health care companies are entering the market and seeking to unseat the dominant local players by driving down health care spending. Despite the increasing pace of change, however, Little Rock-based nonprofit providers exercise significant control over a system that continues to be characterized by the prevalence of fee-for-service payments, significant levels of excess capacity and limited enrollment in managed care plans.

Perhaps the most potent force in the market today is the recent alliance between two established, home-grown institutions: Little Rock-based Baptist Health, the largest hospital system in central Arkansas, and Blue Cross and Blue Shield of Arkansas (BCBSA), which covers close to half of all commercially insured lives in the metropolitan area. These entities joined forces in 1994 to form the area's most highly sub-scribed HMO. Baptist Health is also the preferred hospital provider for BCBSA's sizable PPO business, a business that stands to gain

from the insurer's successful bid for the newly combined state employee and public teacher pool.

Significant changes are unfolding in the way health services are organized and paid for in Little Rock as well as in the locus of control of key entities in Little Rock's health care sector. Over the last several years, the dominance of the local institutions has been challenged by the market entry of several national health care companies seeking to build market share by taming what many informants perceive to be high and rising health care costs. The 1994 merger of health care giants Columbia and HCA brought under their control Doctor's Hospital, a medium-size institution located in the heart of Little Rock's medical-industrial complex.

Shortly after, Columbia/HCA purchased the biggest group practice in town, a move that reportedly set off a spate of physician practice acquisitions by the two major locally owned hospitals. In February 1997, Columbia/FICA acquired a smaller community hospital south of town, adding yet another institution to the company's portfolio in central Arkansas. All eyes are also on the Arkansas Heart Hospital, an institution being built by MedCath, a Charlotte based health care company, which opened its doors in early 1997 and is positioning itself to lure lucrative cardiology patients away from several other area hospitals.

National health insurance companies are also a growing presence in the Little Rock market. These companies include New Hampshire-based Healthsource[1]; Prudential, an Atlanta-based concern; and United HealthCare, a Minneapolis-based company that owns the most rapidly growing

HMO product in the area. At the same time, respondents say that intensifying competition for covered lives and employers' sensitivity to health insurance premiums have contributed to a recent decline in the rate of premium growth.

These dynamics have led to a profusion of provider profiling activities, something that distinguishes Little Rock from other markets with moderate levels of HMO penetration and a fee-for-service-dominated payment system. While most profiling initiatives are being used to encourage increased efficiency through provider education, a growing number of health plans in Little Rock are using profiling data to adjust physician payment rates. Little Rock's leading HMO also plans to use its profiling system to select its network physicians based on analysis of those providers' utilization pat terns. However, plan officials are reportedly considering suspending further implementation of that profiling initiative due to resistance of local doctors.

In light of these activities, Little Rock physicians are beginning to organize into independent practice associations (IPAs) and other types of organizations, a trend that marks a shift from a market previously dominated by small-group and solo-physician practices.

It is difficult to predict the course of these changes or the likely impact of change on cost and quality of and access to care. Despite respondents' concern about high health care costs, many also expressed concern over the prospect of reduced provider choice and the influence of managed care companies over physician decision making. And, while the entry of national health care companies was not considered to be a major issue, their influ-

ence may be approaching a critical point, leading to a bigger impact on the local marketplace and an intensified public discussion about the future of Little Rock's health care system.

The Little Rock Community

This case study focuses on the four-county Little Rock/North Little Rock metropolitan statistical area (MSA). With a total population of approximately 550,000, the metropolitan area includes Pulaski County, which contains the cities of Little Rock and North Little Rock; Faulkner County to the north; Lonoke County to the east; and Saline County to the southwest. Interviews were concentrated in the cities of Little Rock and North Little Rock, which include a large share of the county's health care resources.

The community is demographically and socioeconomically heterogeneous, but some important aspects of its profile may predispose the population to poor health status due to the established link between race/ethnicity and poverty on one hand and health status on the other. For instance, while unemployment in the area is low compared with state and national norms, Little Rock has a relatively low median household income compared with the nation as a whole.[2] Almost 20 percent of the MSA's population is African American compared with a national average of about 12 percent. A relatively small proportion of the population is made up of other racial and ethnic minorities. Little Rock does not differ significantly from the U.S. average with respect to other socioeconomic variables, including

levels of educational attainment and the proportion of the population that is elderly.[3]

Arkansas ranks as the fifth highest state in terms of its overall rate of preventable diseases.[4] With regard to morbidity among Little Rock-area residents, the major sources are high levels of substance abuse, hypertension, diabetes and sexually transmitted diseases, according to respondents.

Data indicate a significant problem in maternal and child health: Little Rock's overall infant mortality rate is almost 10 percent higher than the national average. Moreover, the infant mortality rate for nonwhite residents exceeds the rate for white residents by 173 percent, also somewhat higher than the national norm for nonwhites.[5] High rates of infant mortality may be related to high teenage pregnancy rates, high proportions of low-birth-weight deliveries and low levels of prenatal care compared with U.S. norms and public health goals such as Healthy People 2000. Overall, Little Rock's age-adjusted mortality rate is comparable to the U.S. average.[6]

THE HEALTH CARE MARKET

Little Rock is a self-contained health care system that includes the state's largest insurer, 10 acute care hospitals and physicians practicing in most major specialties. High levels of inpatient utilization and an oversupply of acute care hospital beds characterize Little Rock. The number of hospital beds and inpatient days per 1,000 residents is more than 50 percent higher than the U.S. average. Hospital occupancy rates are also low.[7]

These statistics suggest significant opportunities for cost savings, opportunities that may help explain the growing presence of national hospital and health insurance companies in the Little Rock market.

The City of Little Rock contains nearly all of the metropolitan area's inpatient resources. Little Rock hospitals draw patients from throughout a multistate region for highly specialized care. For example, Little Rock's Children's Hospital is the only hospital in the nation with a mobile pediatric heart-lung bypass machine that can transport sick children from a several-hundred-mile radius. Moreover, two of the biggest area hospitals are seeking to affiliate with hospitals outside the metropolitan area, a move that could significantly extend their geographic coverage. Local organizations currently retain control over the hospital sector, but that control is loosening, particularly with recent acquisitions made by Columbia/HCA, the nation's biggest hospital chain.

Like hospitals, physicians are concentrated in the Little Rock/North Little Rock area. Approximately 85 percent of the physicians practicing in the state have their principal offices located in the city or in close proximity. Outlying areas have very little primary care capacity and even fewer specialist resources.[8]

BCBSA, a not-for-profit corporation that dominates the local insurance market, covers more than 40 percent of commercially insured lives in the area. However, like the hospital sector, control of Little Rock's HMO market is mixed, with an increasing number of national, for-profit insurance

companies and HMO chains, including United HealthCare and Healthsource, making substantial inroads over the last several years.[9] While most businesses in Little Rock are small, many of the larger businesses in the area use these national or regional carriers for one or more insurance products and supplement the list with local HMOs. For instance, Alltel, a national electronics company with employees in a number of states, offers its Little Rock employees three local HMOs in addition to a self-insured fee-for-service plan administered nationally by United HealthCare's Minnesota-based parent.

LEADERSHIP AND DECISION MAKING

Many respondents said that local hospitals and other health care providers retain much control over the community's health care system because no formal or informal community-level decision-making processes exist. The hospital sector's influence is reportedly a function of several factors:

- the importance of hospitals to the economic vitality of the community;
- the significant resources hospitals have at their disposal;
- the dominance of specialists in Little Rock's health care system; and
- hospitals' success in seating prominent boards of directors made up of business and other leaders.

Although Little Rock business leaders sit on the boards of the major hospitals, some respondents said that they do not use their influence to encourage

hospitals and affiliated physicians to operate more efficiently.

Physicians are also reported to have considerable influence in shaping the health care system, but like hospitals, most of this influence appears to be exercised in an ad hoc fashion. One major exception is the Arkansas Medical Society's success in the 1995 legislative session lobbying for passage of the state's "any willing provider" law. Recently struck down by a U.S. District Court judge, the law would have limited the ability of managed care plans to exclude physicians from their panels.

As a group, purchasers do not appear to exercise collective influence over the health care system, either through advocacy or market-based activities. However, the business community established the Arkansas Health Care Coalition, a statewide organization, in an effort to forestall attempts to enact anti-managed care legislation, such as the any willing provider statute, a measure the group believed would have limited HMOs' ability to hold down health care costs had it not been struck down by the court. The coalition includes major Arkansas insurance companies and two hospitals that are active sponsors of managed care products. The coalition's first act was to hire the former governor's chief of staff as its executive director; however, the organization's clout has yet to be tested. Moreover, at the time of the site visit, the group had not succeeded in recruiting some of Little Rock's major employers.

Organized consumer groups and grassroots organizations appear to play a very limited role in community-level decision making about the health

care system. Several organizations advocate for vulnerable populations: the Legal Aid Society of Greater Little Rock, which has wielded significant political influence in the past on behalf of the poor; the Arkansas Minority Health Commission; Seniors United for Progress; and the Arkansas Advocates for Children and Families, a statewide group that has influenced state Medicaid policy.

External Forces Affecting the Health System

PUBLIC POLICY

In past years, Arkansas state and local policy makers have been relatively quiescent on matters concerning health policy. State policy, with respect to regulation of the private health care system, has often favored market forces over government action. For example, the state insurance market reforms enacted in 1991 permitted wide variation in health insurance prices and unlimited pre-existing condition exclusions, and state legislators rejected coverage expansions and other elements of former Gov. Jim Guy Tucker's 1995 health reform agenda. Legislators also repealed the state's certificate of need program (CON) for acute care facilities shortly after the sunset of a federal requirement mandating states to implement such programs.

State policy makers have pursued a relatively conservative approach with respect to the state's Medicaid program. Until recently, state

officials have not sought to expand the Medicaid program to "optional" populations such as school-age children and adults above certain levels of poverty. State Medicaid policy has also embraced primary care case management (PCCM) as a way to control costs and improve access to care rather than offering risk-based Medicaid managed care programs that other states have pursued. Under Arkansas's PCCM program, primary care physicians are paid a set fee to manage referrals and coordinate care for each assigned Medicaid patient. Arkansas's Medicaid program is also notable for having one of the highest match rates in the country: The federal government provides the state with $.73 out of every Medicaid dollar it spends, a reflection of Arkansas's historically low per capita income levels relative to other states.

More recently, however, state health policy activity has increased. As indicated above, in 1995 Arkansas enacted one of the nation's most sweeping any willing provider laws, which requires all health plans to accept physicians and other licensed health professionals into their network as long as the provider agrees to the plan's fee schedule and other contract terms and conditions. The law was never enforced, however, and was struck down by the court. Proponents of the legislation have appealed the decision. Also in 1995 the legislature merged state employees and public school teachers into a single insurance pool, the only major provision of Governor Tucker's more sweeping health reform initiative to survive.

In 1997 state legislators enacted an initiative

called ARKids to provide subsidized insurance coverage to uninsured children across the state. Close to 20 percent of the state's population has no health insurance, with children and young adults comprising a disproportionate share of that figure.[10] Under the ARKids program, which is awaiting approval by the U.S. Health Care Financing Administration and slated for implementation in the fall of 1997, general revenues will be used to subsidize the purchase of insurance for children in families whose income is up to 200 percent of the federal poverty level. The program will be run through the state's Medicaid program. Policy makers estimate that 90,000 children are eligible for the program statewide; ARKids aims to enroll more than half of these children during the program's first two years.

PURCHASING

Competing forces have limited private purchasers' influence over the shape of Little Rock's health care system. Many employers are small, low-wage firms that either do not offer health benefits or are extremely sensitive to premium increases. On the one hand, this local economic feature, along with the recent consolidation of public purchasing power described above, tends to drive competition among health plans to hold down premiums. On the other hand, other factors, the importance of the health sector in the area's economy, tend to temper demands for lower costs and, as a result, health system innovation that brings about cost reductions.

Private Purchasing

Demand for health insurance- or the lack of demand- among private employers is influenced in large measure by the nature of Little Rock's economy. While unemployment is low and competition for workers high, a dynamic that typically increases purchasers' demand for health insurance, many Little Rock-area firms are small companies with low profit margins, thereby reducing demand. Moreover, many new jobs being created appear to be non-unionized and low wage. Between 1990 and 1996, the manufacturing, finance, real estate and insurance sectors posted relatively anemic job growth gains in the 4 to 8 percent range compared with increases in excess of 30 percent among the construction and service jobs, sectors that are less likely to offer health benefits.[11]

These economic forces have driven private employers to be extremely price sensitive regarding their health benefits. Several informants reported that employers have responded to premium increases by cutting back on benefits, moving to self-insured arrangements to reduce their health benefits costs or dropping coverage altogether, an action that many said has led to a decline in employer-based health insurance. As a result, many health plans have begun to redouble their efforts to control costs by, for example, reducing provider payments and controlling utilization. In addition, a number of major insurers, including BCBSA and Healthsource, are increasing their capacity to service self-insured arrangements, indicating that health plans are taking this trend very seriously.

While these dynamics tend to keep Little

Rock's health sector focused on bottomline costs, other factors serve to defuse this pressure:

- A large number of Little Rock's biggest employers are health care providers. After state and local governments, most of the remaining large employers in Little Rock are hospitals, which view health care spending as a principal source of revenue as well as an expense. These institutions, combined with the University of Arkansas for Medical Sciences and BCBSA, employ 11 percent of Pulaski County's total work force.
- Given the prominence of health care in the area's economy, many non-health related firms, especially utilities and those in the service sector, view hospitals as valued customers and are loath to push too hard on costs.
- A number of large firms' headquarters are out of state, leading to what one respondent described as an "absentee landlord" problem. These employers include the federal government (with 9,900 workers), the U.S. Air Force (6,890), Union Pacific Railroad (2,000) and Southwestern Bell (1,980).[12]

In addition, employers in Little Rock are reportedly extremely sensitive to restrictions on provider choice, diminishing the market appeal of HMOs featuring limited provider networks. Such concerns have also led to a proliferation of point-of-service (POS) plans, which allow employees to receive services from non-network providers.

However, this growth may be due more to a requirement applicable to the public employee pool (described below) than to preferences expressed by private purchasers.

Public Purchasing

Perhaps the most potent purchasing force throughout the state is the Arkansas State Employee and Public School Personnel Insurance Board, created by state law enacted in 1995. The Board purchases health insurance for 70,000 state employees and public school teachers, with the largest number residing in the Little Rock area.[13]

The Board's purchasing process appears to have stimulated the growth of managed care in the Little Rock area. Within the first year of the program, 22,000 of the 38,000 teachers participating in the pool migrated from indemnity products to point-of-service (POS) plans. This transformation has had the biggest impact outside of Little Rock where providers have been more resistant to managed care. According to respondents, many of these providers are now finding that they have to sign up with managed care plans in order to retain their patient volume, a large portion of which is public employees.

The Board also introduced a pharmaceutical benefits management program despite vocal protest by local pharmacists and key state legislators. Finally, public employees are making more cost-conscious choices among plans due to a change in the employer contribution formula, which increases employees' share of the premium for more expensive plans. Respondents

predicted that, over time, this contribution method will drive more employees into managed care plans.

The market impact of the pool has been limited by law, which requires the pool to offer all POS plans in the area, and by a decision made by the Board to eliminate the closed-panel HMO offerings after those bids came in uniformly above premium bids for the carriers' POS products. This decision had the effect of moving thousands of state employees from closed-panel HMO arrangements to plans with looser network arrangements. The Board's selection of a PPO vendor also had important implications for the market position of several key health plans in Little Rock, including QualChoice, the University of Arkansas for Medical Sciences-sponsored plan that lost the state contract, and BCBSA, which won it.

Compared with the Board's program, Medicaid is a less active public purchaser and, as noted earlier, has not expressed interest in replacing its primary care case management (PCCM) program for the Aid to Families with Dependent Children (AFDC) population with a risk-based Medicaid managed care program. In fact, its advocates claim that the PCCM program has saved the state substantial sums. Moreover, the state legislature recently refused to grant the Medicaid Department authority to contract with a managed care firm for behavioral health services. Until recently, the state has taken a more assertive purchasing posture by directly contracting for inpatient obstetrical services with Columbia Doctors' Hospital and University Hospital- a

purchasing arrangement that reportedly provides the state with significant discounts over list prices for these high-volume procedures. In April 1997, however, the state moved away from selective contracting for these services. The state now pays 85 percent of per diem rates to any Medicaid-qualified hospital that agrees to provide care at such a discount.

Organization of the Health Care System

Little Rock's health care system is marked by strong alignments between a number of leading hospitals and health plans. Links between hospitals and physicians remain relatively weak despite recent acquisitions of many area practices. Relationships between hospitals and health plans are driven in large part by shared equity arrangements with limited administrative or clinical coordination or integration across the participating organizations. The dominance of fee-for-service payments and purchasers' demands for broad physician panels have created a physician sector that is not organized into highly defined networks or large practice arrangements. Yet at the same time significant changes appear to be taking place in the way physicians are paid and organized. The market entry of several well-capitalized national health insurance companies and hospital chains is likely to alter this current balance of power.

HOSPITALS

The Little Rock metropolitan area is home to 10 short-term, acute care hospitals, eight of which are

located within the city limits of Little Rock and North Little Rock. The most powerful area hospital system is Baptist Health, which owns Baptist Medical Center in Little Rock and Baptist Memorial Medical Center in North Little Rock. Together these institutions have more than 1,000 acute care beds, accounting for 42 percent of the MSA's total.[14] The system also owns Baptist Medical Center of Arkadelphia and the 120-bed Baptist Rehabilitation Institute. One way in which Baptist Health has secured its position in the Little Rock market is through its strategic partnership with BCBSA, and its physician affiliates are equity partners in the area's biggest HMO, Health Advantage HMO. In return for its equity share, Baptist retains the exclusive contract for general inpatient services for the HMO's 40,000-plus members. In addition, Baptist serves as the preferred provider for BCBSA's PPO products and is actively developing a statewide provider network of hospitals outside the area.

Perhaps the most significant competitor to Baptist in terms of size and market clout is St. Vincent's Medical Infirmary, a 566-bed hospital owned by the Kentucky-based Sisters of Charity of Nazareth.[15] St. Vincent's is aligned with Healthsource Arkansas Ventures, Inc., through a joint venture with the HMO's New Hampshire based parent, and is the exclusive hospital provider for the health plan in the Little Rock service area.

St. Vincent's is also reported to be the prime force behind an attempt to establish a regional provider network called Novasys with out-of-area hospitals, most of which are owned by Tenet, a

large national hospital chain. Respondents described the goals of this network as twofold: to check the growing influence of the Baptist/BCBSA alliance outside the metropolitan area and to establish a regional provider base that could help St. Vincent's secure direct contracts with regional employers.

While St. Vincent's is a full-service hospital that reportedly enjoys a substantial degree of patient loyalty and a reputation for being patient-focused, its position in the market may be weakening due to high costs and a rocky relationship with its managed care partner. In fact, several respondents noted that the institution recently underwent a round of layoffs and reductions in hours to reduce its costs.

Several other acute care hospitals operate in the area:

- University Hospital, operated by the University of Arkansas for Medical Sciences (UAMS), which provides a large share of Little Rock's charity care and many of the area's most sophisticated procedures, such as bone marrow transplants and experimental procedures;
- Arkansas Children's Hospital, a regional center of excellence for pediatric tertiary care, which, like St. Vincent's, has reportedly laid off staff to bring down costs;
- two smaller community hospitals in Saline and Faulkner counties;
- two small military hospitals; and
- a large Veterans Affairs Medical Center complex with more than 900 beds and

specialty ambulatory care clinics that generate among the highest numbers of outpatient visits in the VA system.

Among the most significant changes unfolding in Little Rock's hospital sector is the emerging presence of Columbia/HCA. In 1994, control of the 340-bed Doctor's Hospital shifted from HCA to the newly merged Columbia/ HCA. Doctor's Hospital was previously owned by HCA. Doctor's has a reputation as a high-quality hospital with a favorable payer mix and a strong obstetrics program: it held the state Medicaid contract for inpatient obstetrical and newborn cam until April 1997, when the state terminated selective contracting for these services.

Around the same time as the 1994 merger, Columbia/HCA purchased Columbia Family Practice, the largest medical group in town. While these acquisitions caused many in the health care system to take notice, they did not receive a great deal of public attention for two reasons: First, the acquisitions did not raise the specter of for-profit conversion of valued public institutions, an issue in other communities where Columbia/HCA has been active. Second, many consider Doctor's Hospital to be weak due to its limited range of service offerings and its high number of unfilled beds, leading some to downplay the significance of Columbia/HCA's control over that institution.

Stakeholders' interests were piqued early in 1997, however, when Columbia/HCA announced its intention to acquire Southwest Hospital, a 125-bed community hospital also located in Little Rock proper. News reports of the company's underlying area strategy may have done more to

sound an alarm than the transaction itself did. In press interviews, a Columbia/HCA spokesman described his company's newest acquisition as part of a strategy to build critical mass in central Arkansas- a strategy similar to one being pursued in Northwest Arkansas where Columbia/HCA now owns or manages several hospitals and home health care facilities.

In the article, the Columbia official went on to name the four biggest hospitals in Little Rock, all not-for-profits, as potential acquisition targets, stating further that he didn't want to "strike fear into the hearts of the existing facilities, but if none of these institutions was willing to sell, building a new hospital in the area is definitely an alternative."[16] In news reports, hospital executives either declined comment or denied any interest in a sale.[17] Indeed, respondents interviewed for this study reported that the Southwest Hospital transaction has sparked concern among nonprofit institutions and stimulated discussions in many quarters about how best to keep Columbia/HCA at bay.

Another major development with a potentially significant impact on local institutions was the March 1997 opening of Arkansas Heart Hospital. Like the new hospital, a number of hospitals in town, including Baptist, St. Vincent's and University Hospital, offer full-service cardiology and cardiovascular surgery programs. The Arkansas Heart Hospital was built by MedCath, a Charlotte-based health care company specializing in cardiac care and management of specialty hospitals. More than a dozen local cardiologists with ties to both Baptist and St.

Vincent's are equity partners in the venture. The Arkansas Heart Hospital poses a significant threat because cardiology programs are reportedly big moneymakers for these institutions, generating as much as one-third of each hospital's total revenues.

Arkansas Heart Hospital has yet to secure a managed care contract, and its investors anticipated limited success in this regard given the equity position of its major competitors in two of the area's most highly subscribed HMOs. However, a lack of managed care contracts does not restrict Arkansas Heart Hospital's ability to compete for patients enrolled in traditional health insurance plans, who represent the largest share of Little Rock's commercially insured population. Arkansas Heart Hospital's presence has touched off an intense advertising blitz by local hospitals to secure their existing share of the cardiology and cardiovascular surgery market. Respondents also reported that the new hospital's opening has generated significant competition for specialized nursing and mid-level technical staff.

PHYSICIANS

Little Rock *has* a healthy supply of physicians. In 1994, for instance, the metropolitan area had 11 percent more primary care physicians per capita than the U.S. average and 47 percent more physicians in non-primary care specialties than the national norm.[18] This supply may reflect the fact that the area is home to several medical training programs. UAMS trains physicians and sponsors

residency programs at University Hospital, Children's Hospital and the VA. Baptist Health trains a large number of the state's nurses at its two Little Rock-based acute care institutions. While physicians in Little Rock tend to practice in small, single-specialty practices, several larger group practices exist: Columbia Family Practice, a primary care-dominated practice with 35 full-time-equivalent (F1E) medical staff that has hired a number of specialists over the last two years, and the Little Rock Diagnostic Clinic, an independent 27- member multispecialty clinic located near the Baptist Medical Center campus.

One of the most visible changes in the organization of Little Rock's health care system is the recent acquisition of physician practices by several leading area hospitals. According to respondents, Columbia/HCA set off the buying spree when it purchased Columbia Family Practice, the area's largest physician group.

Other hospitals, including Baptist and St. Vincent's, reportedly followed suit in a series of defensive maneuvers. Despite the community's focus on these acquisitions, however, many respondents questioned whether their impact is proportionate to the attention they have generated given two aspects:

- Many respondents reported that only a small proportion of physicians in the area actually work in practices owned by the hospitals.[19]
- There is a widely held perception that these acquisitions were not part of a well-thought-out strategy, and that hospitals are now realizing they may have acted too

precipitously.

Physicians have also played a major role in a number of lower-profile, but potentially important, changes in the organization of Little Rock's health care system. Respondents reported that over the last year or so, a large number of physicians have joined together in formal independent practice associations (IPAs) and in less formal practice groups, marking a significant shift in the traditional organization of physician practice in the community. Examples of some of these new arrangements include the recent establishment of two separate primary care IPAs; an informal affiliation of all the practicing urologists in town; the formation of a new large multispecialty group; the merger of two cardiology groups associated with the Arkansas Heart Hospital, a prelude to the opening of that institution; and a merger of several OB/GYN practices that plan to practice together and, perhaps, to undertake collective Respondents noted that these endeavors reflect an attempt by physicians to combat potential reductions in income and clinical autonomy.

INSURERS AND HEALTH PLANS

While the dominant forms of commercial insurance in Little Rock are traditional indemnity-based coverage and PPO plans that allow enrollees to see out-of-network providers for an additional copayment, more individuals are moving into managed care arrangements. Roughly 18 percent of the metropolitan area's population is enrolled in HMOs.[20] These plans tend to be loosely

structured IPA-type models in which health plans contract with providers who see HMO patients and non-HMO patients, and under which payments remain predominantly fee-for-service. According to respondents, only 10 to 15 percent of provider payments in the area are capitated; most physicians in managed care arrangements are paid on a discounted fee schedule in combination with withholds that are returned to physicians only if they meet predetermined performance targets.

A number of health plans competing in the market are relatively new to the Little Rock area. In fact, none of them had a presence in the market prior to 1992. These plans include:

- United HealthCare, the second-largest HMO in the metropolitan area and reportedly the fastest-growing health plan in the market (22 percent enrollment growth between 1995 and 1996);
- Healthsource, with a strong base of HMO enrollees and a large number of individuals enrolled in products offered by its newly acquired third-party administrator; and
- Prudential Healthcare, a national insurance company that offers both HMO and PPO products in the market.

Supplementing these national insurers are three homegrown HMOs: Health Advantage, the biggest HMO in central Arkansas; American Health Care Providers, in operation since 1985, making it the area's oldest HMO; and

QualChoice, an HMO sponsored by the University of Arkansas for Medical Sciences, which, until recently, has focused on public employees and received a commercial HMO license in the fall of 1996.

Respondents noted that the entry of these new health plans has led to increased marketing efforts and premium competition. A number of respondents asserted that several health plans are "low-balling" their rates to build market share even though the underlying rate of increase of medical costs has not slowed. As a result, revenues collected from insurance companies have not always kept pace with amounts they pay to medical providers. For instance, several respondents accused United HealthCare's parent company of subsidizing premiums quoted in Arkansas, a charge refuted by local company executives. Others noted that in 1996, BCBSA announced a $22 million operating deficit and a $5 million operating deficit for Health Advantage. This is another indication that competitive pressure may be holding down premiums, perhaps below a sustainable level.

Purchasers interviewed for this study, however, had mixed views about whether premium costs are really abating in Little Rock. Some asserted that the rate of premium growth is accelerating for many plans in the market.

Despite the mounting competitive challenge posed by out-of-state plans, BCBSA appears to retain a relatively strong position in the local market for several reasons:

- BCBSA still enjoys strong name recognition, and BCBSA-affiliated products reportedly

cover more than 40 percent of all commercially insured lives. With 5,000 members enrolled in its Medicare HMO, and three-fourths of the area's large and growing managed workers compensation market, BCBSA's large base of covered lives gives it a great deal of leverage in negotiating rates with local providers.

- The insurer's successful PPO bid for the state employee and teachers pool increased its enrollment base and market clout, particularly in areas of the state outside Little Rock and North Little Rock, where teachers represent a large share of the commercially insured population.
- BCBSA has forged a strategic joint venture with the Baptist system, the region's dominant hospital provider.

One significant change health plans are making is use of more sophisticated payment arrangements to encourage participating providers to practice medicine more efficiently and to increase patient satisfaction. Such initiatives supplement discounted fee-for-service payment methods rather than replace them. For example, in January of 1997, Health Advantage introduced a controversial payment system that adjusts physician payment levels using providers specific "quality index" scores. These scores are numeric values that indicate the extent to which a provider's practice varies from the health plan's explicit practice guidelines. Physicians with above-average scores receive an increased payment for each service billed (for example, 115 percent of the fee

schedule), while providers with scores at the lower end of the range receive discounted payments as low as 80 percent of the basic fee schedule. The health plan also considered using the profiling system to remove physicians with consistently low scores from the HMO's list of participating providers. Given the high level of physician concern about the profiling effort, Health Advantage is reportedly reconsidering its use of index scores altogether.

In another move that could significantly transform Little Rock's delivery system, Health Advantage announced that this year it will offer global capitation to providers that organize themselves into self-selected sub-networks. Under these arrangements, patients would be able to "self-refer" within their primary care doctor's sub-network, a feature that allows members to see network providers without referral from a gatekeeper. To date, no Health Advantage providers have stepped forward to participate in such an arrangement.

Other health plans have also begun to make changes in the way they pay providers. United HealthCare has started to adjust physician payments using member satisfaction data and plans to adjust payments based on severity-adjusted utilization data sometime in 1997. The Minnesota-based health plan is also considering capitating payments to specialists in the future. Healthsource has introduced a system that rebates primary care doctors' withhold based on an " efficiency index" that reflects severity-adjusted utilization data. Healthsource is already the driving force behind much of the existing capitation in the area; its

contract with St. Vincent's makes the hospital responsible for medical costs incurred by Healthsource enrollees in retum for 75 percent of the HMO's premiums, leaving the hospital at full financial risk for all costs that exceed this dollar amount.[21] Last year Healthsource unsuccessfully tried to talk Southwest Hospital into a similar arrangement.[22]

RELATIONSHIPS AMONG HOSPITALS, PHYSICIANS AND HEALTH PLANS

Many of Little Rock's HMOs are jointly sponsored by insurers and hospitals through shared equity arrangements. These relationships bind together, at least in the short run, the fate of some of Little Rock's most important health care organizations. Shared equity arrangements are the foundation of both Health Advantage, a partnership between Baptist and BCBSA, and Healthsource Arkansas Ventures Inc., a joint venture between St. Vincent's Infirmary and the New Hampshire-based HMO company. Moreover. the recently licensed QualChoice network is owned by the University of Arkansas for Medical Sciences, which also owns and operates University Hospital.

The principal characteristic that binds these organizations together, however, is a shared financial stake in the success of the products. Health Advantage is an equity arrangement among three parties that share in the operating profits or losses of the venture: BCI3SA. which has a 50 percent stake in the venture; Baptist Health, which has a 25 percent stake; and the 200- member Baptist physician group, which holds the remaining

equity in the HMO. Similarly, Healthsource is a 70/30 venture between the health plan and St. Vincent's Infirmary. These joint ventures have not led them to organization integration, but rather only a limited degree of financial and administrative integration. For instance, health plan and hospital officials reported that Health Advantage provides Baptist with access to up-to-date administrative information that allows the hospital to verify patients' insurance coverage on-line. Respondents had conflicting views about the success of efforts to create a "data warehouse" that attempts to combine clinical information from BCBSA's claims files with hospital records and other data sources. The goal of that system would be to enable providers to develop "episodes of care" and other analyses to aid clinical practice.

Views were mixed on the overall market impact of these hospital/health plan alliances. Some respondents asserted that health plans and local hospitals limit the ability of plans to negotiate as aggressively on price as they would be able to if they had a more arms-length relationship with their hospital partners. Others, including health plan representatives, asserted that hospitals are willing to offer their best price to the HMOs since they have a strong interest in the products' success in the market and because the contract terms guarantee patient volume.

While the BCBSA/Baptist relationship appears to be on firm footing, a number of respondents reported that tensions between Healthsource and St. Vincent's cloud those organizations' future relationship and potentially weaken the position of both companies in the Little

Rock market: Healthsource's ability to compete on premiums may be hobbled by alleged high costs at St. Vincent's; hospital officials are reportedly dissatisfied with the terms of the joint venture agreement.

Hospitals' acquisition of physician practices is also a potentially important source of cross-sector activity, although these acquisitions are reported to have limited influence on physician referral patterns. Physicians are not required to direct patient volume to the acquiring hospital. Indeed, respondents noted that hospitals tend to tread carefully in such matters lest they run afoul of federal anti-kickback regulations; they merely purchase "good faith," as one respondent called it. In some cases, this good faith is yielding healthy returns. For example, while only 45 percent of the strong economic relationships between patients seen by doctors at Columbia Family Clinic are admitted to Columbia Doctor's Hospital, this is reportedly up from 10 percent prior to Columbia/ HCA's purchase of the practice.

In addition to practice acquisitions, management service organizations (MSOs) appear to be hospitals' preferred way to build stronger links between hospitals and community doctors. Several hospitals, including Baptist and St. Vincent's, sponsor MSOs. Respondents did not emphasize the importance of physician-hospital organizations (PHOs) as a means of organizing medical practices or carrying out contract arrangements, although St. Vincent's' PHO appears to play an especially significant role in the

allocation of capitated payments for Healthsource enrollees.

Clinical Practice and Delivery of Care

With a few notable exceptions, respondents did not identify significant changes taking place in clinical practice or delivery of care. Clinical practice can be characterized by the following observations:

- Physician referral patterns in Little Rock are largely informal and relatively undefined.
- Physicians- not health insurance companies or their agents- drive clinical decision making, with specialists still controlling a large number of those decisions.
- The balance of power between specialists and primary care physicians may be shifting slowly to the latter.
- Profiling information and other sources of data are increasingly being used to make clinical decisions.
- Hospitals are using case management and other techniques to reduce the cost of inpatient care.
- Formal and informal group practices are developing.

The emerging shift in power from specialists to primary care physicians may be attributed to two different forces, respondents said: declining professional fees that discourage primary care doctors from referring to specialists as readily as they once did, and the growing number of people in

health plans that use gatekeepers to control specialty care use. No quality issues were raised with regard to this shift in power. Declining fees have also reportedly led an increasing number of specialists and primary care doctors to increase their patient volume by traveling to outlying towns to maintain their income.

Another emerging change in clinical practice is the use of physician profiling data to disseminate information to clinicians and the use of this data by health plans to alter physician behavior through payment incentives. Health Advantage appears to be going to great lengths to get physician support for the profiling initiative, with limited success. For instance, plan officials conduct one-on-one consultations with providers to explain their own profile results and are reportedly recruiting local doctors to lead efforts to modify performance benchmarks and other aspects of the practice, guidelines based on input from other clinicians in the area. Other plans and some area hospitals are using similar profiling tools solely to provide providers with educational feedback in hopes of encouraging practice changes.

Despite these activities, Little Rock's profiling systems still appear to be at a fairly modest stage of development and tend to focus on resource use and medical transactions (for example, total spending per member, average length of stay, number of procedures per patient, etc.) rather than clinical outcomes or other measures that focus directly on quality of care. Moreover, there is no evidence that these profiling systems are looking at episodes of care, a unit of analysis that extends across treatment settings and over the course of an illness or disease.

Respondents said that these limitations restrict the power of existing profiling tools.

A small number of hospitals in Little Rock also report using clinical pathways and other techniques to control the cost of hospital care and improve patient outcomes. Clinical pathways- detailed guidelines for inpatient care- are becoming important care management techniques at both Baptist and University Hospital, although to date such pathways have only been implemented for a handful of conditions.

Baptist Health has also launched case management programs in each of its hospitals. Under these programs, a nurse or social worker is assigned to selected patients with conditions or procedures that tend to result in long lengths of stay. These " care coordinators" use patient care conferences and standardized care protocols, among other tools, to reduce patients' average length of stay. Respondents say this program is largely responsible for both a drop in the hospital's average length of stay of two days over the last two years and a moderate decline in average resource use per admission.

Care of the Poor

Although few respondents identified indigent care as a major health care issue facing the community, Little Rock has a large number of uninsured residents and what appears to be inadequate access to physicians and other outpatient services for the community's poor, uninsured population.

University Hospital is the principal source of inpatient charity care; several other

hospitals provide more limited care to indigent patients. University Hospital's ability to continue serving in this role is uncertain, however, particularly if state or federal action results in cuts in Medicaid payments, the hospital's principal source of subsidies for uninsured patients. Moreover, UAMS sources noted that University Hospital's reputation as the principal provider of care to the poor has complicated the hospital's efforts to draw more private pay patients to its emergency room and outpatient clinics.

The hospital emergency room serves as the principal point of access for many indigent patients, and the site visit team identified few other significant sources of outpatient care for uninsured persons. The only federally qualified health center in the area is a clinic located near the airport, which provides about 5,000 visits a year. Only about one-third of the center's services are provided to uninsured patients, however, and the facility was totally destroyed by a tornado in early 1997. St. Vincent's sponsors a free clinic for poor patients once a week, and the medical society organizes a program to encourage private practice doctors to see indigent patients in their offices, although this program is characterized as quite limited.

A sizable share of the indigent care burden appears to be shouldered by the state Department of Health and, to a lesser extent, by the Veterans Administration system. Although the health department is not organized or sufficiently funded to play a major role in the provision of acute care services, public health

nurses and other staff frequently provide limited primary care during visits for preventive services such as immunizations. Consequently, as the de facto provider of last resort, the Health Department has been forced to divert resources from other activities such as the conduct of more regular health assessments and disease surveillance. The VA medical complex in Little Rock may also be serving a large share of indigent patients. Thirty percent of eligible veterans in the area use the system compared with a national average of about 10 percent, and the VA's ambulatory care clinics also generate 288,000 outpatient visits a year, one of the highest numbers of any VA facility in the country.[23]

Issues to Track

Though still dominated by local institutions and a fee-for-service system of provider reimbursement, Little Rock's health care system *has* been marked by significant changes over the last several years. Most of these changes are due to the increased degree of alignment among hospitals and health plans in the area, the market entry of powerful national health care companies, including Columbia/HCA and United HealthCare, and local employers' sensitivity to premium hikes.

Respondents report an array of perceived changes resulting from these and other market influences. Views of recent changes in insurance premiums were mixed. Some respondents report a slowdown in the rate of cost growth while others assert that premium levels are starting to rise again,

especially for small businesses. Some attributed recent premium increases to an attempt by local health plans to recoup operating losses incurred over the last several years during intense price competition. Others suggested that higher premium costs reflect diminished private sector restraint in light of the demise of government health care reform. Another impact of market change is a reported decline in the number of people covered by health insurance due to a reduction in employer-sponsored coverage for workers and their dependents.

Respondents also said that problems with access to primary care leads many uninsured Little Rock residents to seek basic medical care in hospital emergency rooms. The majority of Little Rock's insured population, however, was said to be highly satisfied with quality of care as well as increased provider choice through POS plans and managed care products that do not restrict referrals to physicians within a network.

Looking forward, the pace of change in Little Rock is likely to increase. A harbinger of this change includes HMOs' use of physician profiling and consumer satisfaction reports to adjust provider reimbursement and the development of physician-sponsored IPAs and other group-practice arrangements in response to the prospect of declining physician income and reduced clinical autonomy.

Several activities bear watching as the future unfolds:

- Several new entities stand to increase their influence over the next few years. These

players include the Arkansas Heart Hospital, whose success will be determined, at least in the short run, by its ability to attract Medicare patients from other area hospitals since most managed care members in Little Rock are enrolled in health plans that have competing hospitals as equity partners. Columbia/HCA also bears watching, because it has announced its intention to become a dominant force in Little Rock's hospital sector. What remains unclear at this point is whether public sentiment will tolerate Columbia/HCA's acquisition of another area hospital, particularly one of the large, nonprofit hospitals that it appears to have targeted. United and Healthsource may also be poised to increase their market presence. According to respondents, however, tension between Healthsource and St. Vincent's may weaken those organizations.

- The implementation and impact of profiling initiatives now being fielded by Health Advantage and other health plans deserves watching. On one hand, these initiatives have the potential to move Little Rock beyond a largely unmanaged fee-for-service system, thereby bringing down health care costs and potentially altering both individual clini-
- cal decisions and dominant patterns of physician practice. It remains to be seen, however, how widely these systems will be adopted and whether they will be implemented without substantial compromise in order to gain the support of participating

providers. Indeed, these efforts could cause a physician backlash as indicated by Health Advantage's reported reconsideration of its profiling initiative and the emergence of IPAs and other types of physician practice arrangements. Moreover, a majority of Little Rock residents are still enrolled in traditional health plans and PPOs, which exercise little oversight or influence over physician practice.

- Another development to monitor is the ability of BCBSA, Healthsource and other insurers to move more of their providers into capitated arrangements. While the bulk of Little Rock's health care payments remain discounted fee-for-service, giowing HMO enrollment could increase health plans' leverage over providers who remain resistant to capitation. The leading edge of this trend may be the growth of Medicare HMOs, especially if enrollment in these plans is stimulated by federal Medicare reforms, as many predict. A move to capitation could also be stimulated, perhaps paradoxically, by successful adoption of the physician profiling initiative described above. For example, linking fee levels to utilization could reduce physician income to the point where local providers would be less resistant to capitated payments.

Finally, as the future unfolds, Little Rock's patchwork system for providing health care to indigent patients is likely to be buffeted by a number of forces. First, increased competition in

the hospital sector could cause hospitals to be less willing to provide charity care in their emergency rooms and outpatient facilities. This situation could be exacerbated by the tenuous competitive position of University Hospital, especially if further Medicaid spending cuts are made. An increase in the number of uninsured brought about by a slowdown in the region's economic growth could challenge existing agreements among institutions currently shouldering the indigent care burden.

According to one analyst, the picture in regard to this last issue may be quite bleak. After a long stint of high economic growth, Arkansas as a whole experienced a sharp economic decline in early 1996, leading to a drop in employment during the second quarter of that year and several layoff announcements. Economic hardships were a factor, particularly in the state's manufacturing sector, which traditionally is more likely to offer health benefits than other sectors of the economy.[24] On the other hand, successful implementation of the ARKids program could ease the financial strain on University Hospital and other major providers of charity care.

For all these reasons, health system change in the Little Rock metropolitan area bears watching. While the future is hard to predict, it will likely not be placid.

NOTES

1 National news reports indicate that CIGNA, the national insurance company, intends to acquire Healthsource. The impact of this sale on Healthsource's Little Rock subsidiary is not yet clear.

2 Per capita income in Little Rock is about

8 percent lower than the U.S. average, while median household income in Little Rock is a full 29 percent lower than the U.S. average. Sources: Area Resource File as of February 1996 Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services. Population data are 1995. Income data are 1993; Bureau of the Census, 1990 projected to 1995 by CACI, Inc.

3 Area Resource File as of February 1996, Office of Research and Planning. Bureau of Health Professions, U.S. Department of Health and Human Services.

4 U.S. Health Care Financing Administration, MedPar Data, 1991.

5 Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services. Data reflect a five-year rolling average from 1988 to 1992.

6 National Center for Health Statistics, Centers for Disease Control and Prevention, March 1997.

7 American Hospital Association, database of the 1995 Annual Survey of Hospitals. Figures do not include long-term units in hospitals. Occupancy rates range from 37 to 75 percent of staffed beds for general acute care hospitals in the Little Rock/North Little Rock metropolitan area (excluding federal facilities). All estimates are unadjusted and therefore do not reflect differences in case mix of age/sex differences between Little Rock and the U.S. populations, or the impact of migration.

8 The Little Rock/North Little Rock MSA has 11 percent more primary care doctors per 1,000

residents and 47 percent more specialists than the U.S. average. Estimates are based on the 1996 American Medical Association Master File and the 1996 American Osteopathic Association Master File. Includes physicians in direct patient care, excluding some specialties (radiology, anesthesiology, pathology), residents and fellows.

9 See page 98 for more details about the entry of these companies into the Little Rock market.

10 U.S. Bureau of the Census, Health Irtsurance Coverage: 1993, Statistical Briefing 5B94-28; Oct. 1994.

11 Arkansas Employment Security Department, 1990-1996; Employee Benefits Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured," February 1996.

12 Greater Little Rock Chamber of Commerce. "Taking Care of Business," 1996.

13 The state maintains authority over benefits provided by local districts because those benefits are financed in large part through state contributions.

14 American Hospital Association, database of the Annual Survey of Hospitals. Figures do not include long-term care units in hospitals, beds at Little Rock's Department of Veterans Administration facility and two smaller federal facilities located on area military bases.

15 Officials of St. Vincent's Infirmary declined to be interviewed for this site visit, so impressions and observations about the institution are based on reports from other respondents.

16 Subsequent press reports announced Columbia/HCA's intention to build a new facility.

17 Plunket, Chuck. "Columbia/HCA Seeks to

Expand its Presence in State," Arkansas *Democrat Gawtte:* February 2, 1996, p. G- 1.

18 Estimates are based on the 1996 American Medical Association Master File and the 1996 American Osteopathic Association Master File. Includes physicians in direct patient care, excluding some specialties (radiology, anesthesiology, pathology), residents and fellows.

19 Some respondents claimed that less than 5 percent of all physicians in the area work in hospital-owned practices, with Baptist Health System owning the largest share. Baptist reports purchasing practices containing 80 physicians with plans to increase this number to 120 over the next several years. According to respondents, the pace of these acquisitions has slowed down significantly over the last few years.

20 InterStudy Competitive Edge Regional Market Analysis 7.1, June 1997.

21 Strategic Consulting Services, " Focus: Little Rock," Executive Bulletin, Spring, 1995, p. 5.

22 Plunket, Chuck. "Healthsource mailing fosters hospital talks," *Arkansas Democrat Gazette,* December 17, 1996, p. D-1; According to the terms of the Healthsource/St. Vincent's joint venture, Southwest Hospital is the only other general hospital provider in Little Rock that Healthsource patients are allowed to see without an additional payment for going out-of-network.

23 Greater Little Rock Chamber of Commerce, Taking Care of Business, 1996, p. 45.

24 Statement of John Shelnutt, Arkansas Institute for Economic Advancement, before the University of Arkansas at Little Rock Economic Outlook Conference, May 24, 1996.

EXHIBIT B TO PETITIONERS' THIRD AMENDED COMPLAINT

Capacity Expands in Unrestrained Market: Community Report, Little Rock, Ark., Winter 1999

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In September 1998, a team of researchers visited Little Rock, Ark., to study that community's health system, how it is changing and the impact of those changes on consumers. More than 40 leaders in the health care market were interviewed as part of the Community Tracking Study by the Center for Studying Health System Change (HSC) and The Lewin Group. Little Rock is one of 12 communities tracked by HSC every two years through site visits and surveys. Individual community reports are published for each round of site visits. The first site visit to Little Rock, in September 1996, provided baseline information against which changes are being tracked. The Little Rock market indudes the four-county Little Rock/ North Little Rock area.

On 1996, Little Rock was still a largely traditional health care market, with a surplus of facilities and services, limited health maintenance organization (HMO) enrollment and predominantely fee-for-service arrangements. However, several developments – including entry of national health care firms, the creation of a state purchasing pool and new alliances between major hospitals and health plans – signaled the promise of significant

change. Yet by 1998, these changes had not unfolded as expected. National firms have not usurped locals' market share, and fee-for-service continues to prevail with few outside pressures, the alliance between the dominant insurer, Arkansas Blue Cross Blue Shield, and the largest hospital system, Baptist Health System, remains a focal point of competition.

Among the key changes shaping Little Rock's health care system today:

- Local providers and plans are partnering with other national firms to bolster their market position and hold the large insurer-hospital alliance in check.
- Physicians are establishing numerous ambulatory surgery centers and merging their practices in an attempt to protect their income and clinical autonomy.
- Both inpatient and outpatient capacity continue to expand, despite existing excess.

Market Shaped by Few Restraints

The Little Rock health care market continues to have few restraints imposed by purchasers or state policy. In an economy dominated by small firms there has been little organized purchaser activity, although private purchasers' sensitivity to both premium increases and restrictions on provider choice has driven competition. The only significant purchaser initiative in recent years was the creation of the Arkansas State Employee/Public School Personnel Insurance Board in 1995. This initiative merged state employees and public school personnel under a joint procurement process now covering

about 73,000 individuals statewide, most of whom live in the Little Rock area. The new purchasing process, along with a requirement that employees pay a greater share of the premium for more expensive plans, spurred rapid growth in managed care and prompted plans to position themselves to compete for enrollment.

Aside from this purchasing initiative, however, the state continues to play a limited role in shaping Little Rock's health care market. Arkansas repealed its certificate-of-need regulations for acute care services soon after the federal mandate for these regulations was lifted, and state legislators rejected health reforms proposed in 1995, reinforcing their preference for a health system driven by market forces rather than one shaped by government. Ironically, at the same time, legislators passed a far-reaching any willing provider law that would have required all plans—including those protected by the Employee Retirement Income Security Act (ERISA)—to contract with all providers willing to accept the plan's fee schedule and other terms and conditions. However, the courts struck down the law, first in 1997 and again on appeal in 1998—thereby preventing it from being enforced.

Unlike the vast majority of states, Arkansas has not moved to enroll the Medicaid population in HMOs, relying instead on a primary care case management (PCCM) program as the major initiative to improve access and control costs for this population. The only other new policy development over the past two years has been the implementation of the state's children's health insurance program, separate from the federal Children's Health

Insurance Program. The state's program has extended coverage to approximately 36,000 children—one-third of projected total enrollment—since it began in September 1997. While the program is expected to help begin to alleviate the state's high rate of uninsurance, which is disproportionately concentrated among children and young adults, it is unlikely to have a major impact on the shape of competition in the market.

Threat of Outside Entrants Fades

At the time of HSC's first site visit in late 1996, it was anticipated that the entry of outsiders would change Little Rock's health care environment. For the past several years, a number of national health care companies had come to Little Rock seeking to build market share. Among the most significant changes in the market was the growing presence of Columbia/HCA. Columbia entered the market in 1994 as a result of its national merger with HCA. The newly merged entity assumed control of HCA's local hospital, Doctors Hospital, and shortly afterward, purchased the largest medical group in Little Rock. Then, in early 1997, Columbia/HCA announced plans to acquire Southwest Hospital and increase its market share through additional acquisitions, sparking concern among local providers about the company's growing role in the market. At the same time, national plans such as United HealthCare, Prudential HealthCare and Healthsource, Inc., were mounting a competitive challenge to local health plans. The entry of these national plans intensified premium competition and plans'

marketing campaigns.

During the past two years, the anticipated threat of outside entrants failed to materialize, as national firms did not capture significant market share from locally based competitors. Many of these firms now have either reduced their presence or retreated from the market altogether. After it failed to gamer its anticipated market share and against a backdrop of national Medicare fraud allegations, Columbia/HCA quickly exited the Little Rock market. Both Prudential HealthCare and CIGNA, which purchased Healthsource, appear to be backing away from Little Rock, although they continue to offer products locally, particularly to service their national accounts. These plans reportedly have not been successful in leveraging the oversupply of hospital beds and long lengths of stay needed to generate anticipated profit margins. While respondents note that United HealthCare appears to have remained a viable national plan in the Little Rock area, it is clear that, despite outside pressures, Arkansas Blue Cross Blue Shield has retained its dominant position in the market.

Local Entities Team Up with Other National Firms

Meanwhile, local providers and plans have established affiliations and joint ventures with other national organizations that have bolstered their market positions. The Arkansas Heart Hospital, a joint venture between local cardiologists and the national cardiac care management company MedCath, Inc., continues to build presence in the market. Discontent with local hospitals

reportedly spurred two groups of cardiologists to approach MedCath and establish The Arkansas Heart Hospital, which opened in early 1997. Since then, the hospital has lured an estimated 10 to 20 percent of cardiac surgical volume away from the two major Little Rock hospital systems. Market observers speculate that the hospital's market power ultimately will depend on its ability to secure managed care contracts. To date, however, most of the hospital's volume has come from Medicare fee-for-service patients.

In late 1997, St. Vincent Health System, one of Little Rock's two major hospital systems, aligned with Catholic Health Initiatives, a national not-for-profit health system. This affiliation provided the financial resources that St. Vincent needed to help strengthen its market position, which was described as weakening at the time of the first site visit. The new financial backing allowed St. Vincent to take advantage of Columbia/HCA's exit and purchase the Columbia/HCA-owned Doctors Hospital and three family clinics. With these acquisitions, St. Vincent was able to expand its service mix and primary care capacity.

Similarly, QualChoice/QCA, a local health plan owned by the University of Arkansas for Medical Sciences (UAMS), improved its market position by aligning with Tenet Healthcare Corporation and other equity partners. Tenet owns four hospitals in other areas of the state and already has ties to the local market through its involvement in NovaSys Health Network, a statewide, providergoverned network. Tenet's investment gave QualChoice access to the capital it needed to expand its offerings and secure new business in the market.

Powerful insurer-Hospital Alliance Held in Check

In 1996, the most potent force in the Little Rock market was the alliance between Arkansas Blue Cross Blue Shield and Baptist Health System, which joined forces two years earlier in a shared equity partnership to form what became the area's most highly subscribed HMO, Health Advantage. Under the arrangement, Baptist Health provides the majority of hospital services for Health Advantage members in the Little Rock area, with the exception of selected pediatric specialty services provided by Arkansas Children's Hospital and services provided by certain hospitals in outlying areas. A similar arrangement is in place for the Blues' preferred provider organization (PPO) product. By 1996, Baptist's hold on this business gave it a clear advantage over its competitors. This partnership, and similar arrangements developed with other hospitals around the state, gave Arkansas Blue Cross Blue Shield added leverage to win managed care contracts.

While the Arkansas Blue Cross Blue Shield/Baptist Health alliance continues to be a dominant force in the market, key local organizations have begun to counter its power through their new associations with national partners. Through its affiliation with Catholic Health Initiative, St. Vincent has improved its financial stability and expanded its presence in the local market. The system bolstered its position by selling its 30 percent equity interest in another national firm, Healthsource. Despite St. Vincent's

stake in the plan and exclusive provider arrangement with it, capitation rates under this contract reportedly proved insufficient to cover its costs. Thus, respondents note that the arrangement turned out to be more of a financial drain for the hospital than a competitive advantage.

St. Vincent has refocused its managed care strategy by pursuing nonexclusive contracts through the provider network NovaSys, which it formed in partnership with Tenet, UAMS and other equity partners in 1996. As an alternative to the Blues/Baptist alliance, NovaSys enabled local providers to join forces with others across the state to offer a substantial statewide network and compete for state employee and public school personnel contracts. NovaSys is now the largest provider network in the state, with 70 hospitals and more than 3,000 physicians.

With this reach, the network positions St. Vincent and its partners to compete with Baptist Health and the strong provider network established by Arkansas Blue Cross Blue Shield.

At the same time, Tenet's parallel investment in the local health plan, QualChoice, appears to be strengthening NovaSys's tie to the plan, allowing it to bolster its position relative to Arkansas Blue Cross Blue Shield. Although there is no corporate relationship between QualChoice and NovaSys, the plan and provider network appear to be more closely aligned as a result of sharing Tenet as an owner. Since this relationship was established, QualChoice reportedly was able to secure favorable rates with NovaSys providers, allowing QualChoice to underbid competitors for the new exclusive point-of-service (POS) contract for the state employee and school

personnel insurance pool. Though other plans offer products to this group—and Arkansas Blue Cross Blue Shield retains the largest portion of this business overall—the ability of QualChoice to secure the POS contract allowed it to more than double its enrollment and begin to make a dent in the Blues' hold on this business.

Physicians Move to Protect Income

Two years ago, while the majority of Little Rock physicians practiced in solo or small single-specialty practices, some had begun to organize into independent practice associations (IPAs) and larger group practices, marking a shift from Little Rock's traditional organization of physician practice. Attempts by health plans to adjust payment rates through profiling, coupled with the expected growth of managed care, heightened fear among physicians about loss of income and clinical autonomy.

As a result, Little Rock's physician market began to consolidate. Columbia/HCA's purchase of the area's largest physician group spurred other hospitals, including St. Vincent and Baptist Health, to acquire primary care physician practices and establish management service organizations (MSOs). Some specialists also moved to organize independently, leading, for example, to the formation of a new large multispecialty group and a loose affiliation of all of the urologists in the market. Hospital acquisition of primary care practices now appears to e slowing in light of concerns that these purchases have not yielded the necessary return on investment and have not increased referrals.

Meanwhile, specialists have continued to aggregate into larger groups and have found new ways to protect their income and clinical autonomy—primarily by establishing freestanding ambulatory surgery centers. The proliferation of these centers in Little Rock during the past two years has been remarkable. Respondents estimate that six centers are under construction, including those established by the large urologist group, Arkansas Urology Associates, and orthopedic groups such as U.S. Orthopedics and OrthoArkansas. At the same time, there continue to be some additional mergers of single-specialty practices; much of this activity appears to be driven by the effort to secure sufficient volume for these new ventures.

Many specialists view these activities as a hedge against fee reductions and loss of clinical control and as a strategy to increase their leverage with hospitals and health plans. Others in Little Rock characterize these efforts as an attempt by specialists to try to corner the market and retain traditional fee-for-service business for as long as possible. Hospitals view these ventures with considerable concern. Threatened by potential losses in outpatient volume, hospitals have sought joint ventures to establish their own ambulatory surgery centers with physicians. Both St. Vincent and Baptist Health have such arrangements in place. For example, t. Vincent established the North River Surgery Center in partnership with another smaller local hospital, the for-profit management company, HealthSouth, and a group of 40 independent physicians. While the development of ambulatory surgery centers is intended to bring physicians more referrals and ancillary income, the long-term impact

of this expansion of capacity and potential fragmentation of the traditional delivery system remains to be seen.

Efforts to Control Costs Are Challenged

At the time of HSC's first site visit, some market observers believed that the infusion of outside players and the growth of managed care would help drive down health care spending and curtail excess capacity in the market. Since 1996, however, Little Rock providers have only increased excess capacity. In addition to the expansion of ambulatory care capacity resulting from the growth of ambulatory surgery centers, the major hospitals continue to increase inpatient capacity. Baptist Health and St. Vincent both are building new acute care facilities in North Little Rock; a new tower at UAMS added 100 inpatient beds; and the Arkansas Children's Hospital opened a new 50-bed neonatal unit. These activities appear to be driven primarily by hospitals' interest in expanding their presence in North Little Rock and the surrounding suburbs to make themselves more accessible and attractive to the residents and physicians in these areas. Since the repeal of certificate-of-need regulation for acute care services, capacity-building continues unchecked, despite the likelihood that these expansions will drive up costs in the long run. Greater cost control through care management also appears unlikely in the near future. In 1996, all of the major HMOs in the market—and, to a lesser extent, the hospitals—had embarked on physician-profiling initiatives in an attempt to influence clinical practice and control costs. Plans were

trying to implement payment methods that linked the level of physician reimbursement to performance indicators. In addition, one plan intended to use information on physician practice patterns to begin dropping high-cost physicians from its local network. Through these initiatives, the HMOs and hospitals hoped to move Little Rock beyond a largely unmanaged fee-for-service system, thereby bringing down health care costs in the market.

By 1998, however, plans had retreated from profiling initiatives in response to physician resistance. According to health plan respondents, physicians objected to linking reimbursement to profiling data and to the quality of the data itself. Implementation was impeded further by limitations of existing data systems.

Several health plans are again cautiously testing the waters with respect to profiling, primarily by focusing on providing physicians with comparative information on practice patterns, without ties to reimbursement. Arkansas Blue Cross Blue Shield is also considering a network-within-a-network strategy that would use profiling data to identify a subset of providers with whom it could develop a lower-priced product. However, the strategy has drawn mixed reactions from physicians.

Issues to Track

Little Rock appears to remain a market with few restraints. Although national firms have proved to be important partners to help local entities gain leverage, the threat that outside entrants would take over seems to have dissipated. Managed care

arrangements have not grown as expected, but providers continue to position themselves for these contracts, while competing for the fee-for-service revenue that is still available in the market.

Health System Change (HSC), a nonpartisan research organization, seeks to provide objective, incisive analyses about health system change that lead to sound policy and management decisions, with the ultimate goal of improving the health of the American public.

Findings from the first round of the Community Tracking Study site visits are documented in *Health System Change in 12 Communities.* The Community Report series documents the findings from the second round. HSC conducts site visits in 12 communities in collaboration with The Lewin Group.

EXHIBIT C TO PETITIONERS' THIRD AMENDED COMPLAINT

Health Care Cost Concerns Intensify in Little Rock, Ark: Community Report, Fourth Visit, Summer 2003

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In January 2003, a team of researchers visited Little Rock to study that community's health system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed nearly 60 leaders in the health care market. Little Rock is one of 12 communities tracked by HSC every two years through site visits and every three years through surveys. Individual community reports are published for each round of site visits. The first three site visits to Little Rock, in 1996, 1998 and 2000, provided baseline and initial trend information against which changes are tracked. The Little Rock market includes Faulkner, Lonoke, Pulaski and Saline counties.

With health insurance premiums continuing to increase, Little Rock residents and employers are growing more frustrated, viewing their situation as untenable. In response, area employers have increased workers' share of premiums and raised deductibles and copayments. But local incomes are

not keeping pace with these higher costs, pricing health insurance out of reach for many workers and their families. Some employees are dropping their employer-based coverage and, if young and healthy enough, finding lower-priced coverage in the individual market. Others are enrolling their children in public insurance programs when they can meet the state's eligibility requirements.

Other notable developments are:

- Hospitals are struggling to maintain revenues as tertiary services continue to shift to hospitals in nearby communities and physician practices expand their capacity to provide ancillary services.
- Medicaid eligibility for adults remains restrictive despite a small expansion, while eligibility for children remains relatively generous.
- The health care safety net has grown stronger as provider finances have improved and capacity has expanded slightly.

Escalating Health Care Costs Burden Low-Wage Workers

Rapidly rising health insurance premiums are prompting Little Rock employers to shift more health care costs to their workers. Not only have employers increased deductibles and copayments—continuing a trend from two years ago—but they also have passed on a higher share of the premium to employees, which, in 2002, grew roughly 10 percent to 15 percent for large employers and 10 percent to 25

percent and sometimes higher for small employers. Employers' overriding goal is to pass along enough costs to mitigate, as much as possible, the financial impact of rising premiums. Compared to other markets, however, Little Rock's lower median family income and higher percentage of the population living in poverty leaves employees hard-pressed to afford the increased financial burden.

There are few large employers in Little Rock, and those that do exist often have only a small concentration of local employees and are unable to influence health care costs significantly. In addition, the absence of labor unions (Arkansas is a right-to-work state) leaves employers comparatively less constrained in passing costs on to their workforce. Observers note that small employers, in particular, are having difficulty maintaining health benefits due to rising costs, and a few have dropped coverage altogether. Some fear more coverage cutbacks if premiums continue to escalate.

Local observers report some employees have opted out of their employer's plan to seek coverage in the individual market, where, if they are young and healthy enough, they can find coverage priced lower than the contribution required by their employer's plan. Arkansas Blue Cross Blue Shield (ABCBS), particularly active in the individual insurance market, has developed specific products targeting these consumers. The situation will become problematic, however, if those Employees left in the employer-based plan are older and in poorer health, since they use health care services more frequently. There are also reports of parents opting for single coverage under their employers' plans and seeking coverage for their children in the individual

insurance market or, if they meet eligibility requirements, in the state's public insurance programs.

Limited Health Plan Competition Frustrates Employers

Employers are frustrated by the limited health plan competition in Little Rock, blaming it in part for the double-digit premium increases of the past two years. Plans argue that premium hikes are the result of providers' demands for higher payments, increased service utilization, new technologies and rising pharmaceutical costs and use. While employers and their workers are paying more, however, health plans are earning higher profits. Plans in the market generally reported improved profits last year, including QualChoice QCA Health Plan, which was on the verge of insolvency two years ago.

Local observers are concerned that insurers continue to leave the market, further diminishing the health plan competition that does exist. The Arkansas Department of Insurance reports more than 60 health insurance companies have left the state in the last five years, although many of these companies appear to be small with relatively narrow market niches such as Medigap. Large national firms are also pulling back from the market. Aetna and CIGNA essentially exited the Little Rock market during the past three years, remaining only to serve national account customers.

The limited health plan competition that exists in Little Rock is due primarily to long-standing and, for the most part, exclusive plan-hospital alliances, which have resulted in a divided

local health care system. On one side is the relationship between ABCBS and Baptist Health System, the two giants in the market, that was created nearly 10 years ago when the two entered into a 50/50 joint venture with the area's largest health maintenance organization (HMO), Health Advantage. The exclusive relationship between ABCBS and Baptist extends to all of ABCBS's products, except indemnity and preferred provider organization (PPO) plans for two large accounts, the State of Arkansas and public school employees. Another exception is that Baptist provides PPO access for a few selected payers. On the other side is the comparatively weaker alliance of QualChoice, University of Arkansas for Medical Sciences (UAMS) and St. Vincent Health System. United HealthCare's network includes the two hospitals in this second alliance. ABCBS, United HealthCare and QualChoice have more than 40 percent, 30 percent and 20 percent, respectively, of the HMO market share in Little Rock. Statewide, however, ABCBS accounts for approximately half of the overall health insurance market.

Plan and employer respondents noted additional factors that discourage more active health plan competition in Little Rock. First, Little Rock's relatively small population may not support extensive competition. In similar small markets, plans' competitive viability may be enhanced if they increase membership by expanding their services statewide, but Arkansas' rural geography and its relatively small population do not support such a strategy. Second, local observers say that the poor health and low socioeconomic status of Arkansas' population dampens plans' interest in the market.

Although local observers report that ABCBS's exclusive arrangements with hospitals throughout the state have helped to limit health plan competition, these relationships may not be as ironclad as was once thought. For example, the exclusive relationship between ABCBS and its hospital provider in Fort Smith ended in January 2003 when ABCBS also contracted with the competing hospital in the market. While this change does not affect the Little Rock market, it may suggest a willingness on the part of ABCBS to consider alternative provider contracting arrangements.

Competition Threatens Hospital Profitability

Although currently profitable, hospitals in Little Rock continue to be concerned with competition that threatens to reduce revenues. The shift of tertiary services to hospitals in nearby communities, begun several years ago, continues, posing a particular challenge to Baptist, which historically has drawn patients from these outlying communities. St. Vincent, which tends to draw most of its patients from the local market area, has been less affected. While growth in the number of ambulatory surgery centers (ASCs) in Little Rock has leveled off in the past two years, Baptist and St. Vincent continue to be open to discussion about joint ventures with physicians in the hopes of maintaining some financial share in the ambulatory surgery business. Yet, hospital service volume is threatened further by the addition of ancillary service capacity to physicians' office-based practices.

Baptist currently has three joint venture ASCs, two of which have been operational since 2000; a third was opened in 2002 as a joint venture with OrthoArkansas, one of three large orthopedic groups in Little Rock. Due to OrthoArkansas' involvement in talks about developing a freestanding specialty orthopedic hospital, Baptist proposed a 50/50 joint venture arrangement with the group. In light of the joint venture arrangement, it is unclear whether development of the hospital will continue. The only other specialty hospital in the market, Arkansas Heart Hospital, has faced numerous challenges since its 1997 opening. For example, plans exclude the hospital from their networks because it competes with their hospital partners.

St. Vincent is also involved in a number of long-standing joint venture arrangements with physicians.

Medicaid Covers More Kids, but Eligibility Tight for Adults

Unlike many other states, Arkansas has used all of its tobacco settlement money for health improvement projects. A state referendum passed in November 2000 expanded Medicaid coverage by using a portion of the state's tobacco settlement money. As a result, eligibility for pregnant women was expanded in 2002 to 200 percent of the federal poverty level, up from 133 percent. Additionally, tobacco settlement money was used to raise Medicaid's cap on inpatient hospital days for adults from 20 to 24 per year. It also has been used to fund smoking cessation and other health promotion

activities and to create a new College of Public Health at UAMS, which began enrolling students in 2001.

Despite recent program enhancements, the state's Medicaid program, which serves approximately 150,000 adults, continues to be among the most restrictive in the nation in terms of eligibility requirements and benefits. Eligibility for those who spend down, for example, is limited to incomes below 22 percent of the federal poverty level. Additional eligibility criteria include a disability determination of six months or more and household assets of no more than $2,000.

In contrast to the limited Medicaid program for adults, advocates and providers generally agree that access for children has improved significantly since the implementation of the ARKids First program. ARKids First was created initially in 1997 as a Medicaid expansion program under a Section 1115 waiver before enactment of the State Children's Health Insurance Program (SCHIP). The state has opted not to switch its Medicaid expansion program to SCHIP, even though such a change would result in an enhancedfederal match of 82 percent, compared with the current 73 percent. To make the change, the state would be required to give up full federal payment for vaccines (under the Vaccines for Children program) as well as forgoing access to the Medicaid drug pricing rebate. Consequently, market observers believe that a switch to SCHIP would not be in the best financial interests of the state.

Two years ago, the state was engaged in a contentious dispute with the federal government over ARKids First. The state, which wanted to allow

parents the choice of enrolling their children in either Medicaid or ARKids First, argued that parents, concerned about the stigma associated with Medicaid, preferred the private insurance look-alike offered through ARKids First. Federal rules, however, required that any child eligible for Medicaid should be enrolled there. In 2001, the Medicaid and ARKids First programs were renamed ARKids First A (traditional Medicaid) and ARKids First B (the Medicaid expansion), respectively. Renaming the two programs, together with a simplified enrollment form and removal of the assets tests for children, helped end the dispute.

Enrollment in ARKids First A continues to grow. Between March 2002 and March 2003, enrollment in ARIGds First A grew 23 percent (more than 30,000 children), while that in ARKids First B was relatively flat. This growth is attributed in large part to a more streamlined enrollment process. Approximately 235,000 children currently are enrolled in the ARKids First program —177,000 in ARKids First A and 57,000 in ARKids First B.

Although Arkansas' public insurance programs have been relatively stable in recent years, the state faced revenue shortfalls in fiscal years 2002 and 2003 that resulted in cost-containment mandates across state govemment. Nevertheless, Arkansas has grappled with a projected budget deficit in excess of $100 million for each year in the 2004 and 2005 biennium (approximately 3% of the state's total budget), which threatens the status quo of state-funded programs. Gov. Mike Huckabee proposed new taxes to fund the anticipated shortfall. In May 2003, the state legislature approved new taxes on cigarettes, other tobacco products and individual incomes. Potential

tightening of eligibility for public programs and restricting benefits is under discussion; however, these new taxes appear to have staved off significant cuts in Medicaid and ARKids First. Although the details remain to be worked out, the state's willingness to assess new taxes signals its *desire* to preserve existing public programs.

Despite its budget problems, Arkansas continues to explore mechanisms to expand health insurance coverage. The state recently submitted a waiver under federal Health Insurance Flexibility and Accountability demonstration guidelines to draw on the state's SCHIP allotment to extend buy-in coverage to uninsured workers and their spouses earning below 200 percent of the federal poverty level. Employers currently not offering insurance would transfer funds to the state, to be matched by the federal government. Other waivers waiting for federal approval include a prescription drug program for elderly Medicare beneficiaries earning below 100 percent of the federal poverty level and a limited benefit for approximately 15,000 food stamp-eligible adults with incomes less than 35 percent of the federal poverty level. These last two waivers propose using part of the state's tobacco settlement money as the state's match for federal funds. Even if the waivers receive federal approval, state budget constraints may delay implementation.

Improved Finances, New Capacity Strengthen Safety Net

Advocates and other market observers say that health care services generally are available to low-income people who seek care. However, access in a broader sense may be more problematic than perceived
due to low expectations and lack of awareness of safety net services in Little Rock. Some observers also expressed concern that people do not seek care until the need becomes so acute that, when care is received, it is often more expensive and less effective than if it had been provided in a more timely fashion.

The majority of safety net services in Little Rock are provided by UAMS and Arkansas Children's Hospital. Two years ago, UAMS, the primary safety net provider in Little Rock for adults, faced major financial deficits. More recently, however, the higher limit on inpatient hospital days paid by Medicaid, coupled with more favorable contractual arrangements with payers and improved patient collections, has led to a financial turnaround and profitability. At the same time, Arkansas Children's Hospital also improved financially compared to two years ago due mainly to favorable managed care contractual arrangements, an influx of Medicaid upper payment limit and disproportionate share hospital funds and new federal graduate medical education funding provided to children's hospitals. In addition, the hospital has benefited from a larger number of previously uninsured children now covered through

the ARKids First program. Because it is a niche provider of children's health care services, Children's is the only hospital in the market that participates in all of the health plans' networks.

New, though limited, safety net capacity has been added in Little Rock. For example, two new community health centers have opened during the past two years. Jefferson Comprehensive Care System operates these centers (plus an older one) as satellites of its main location in Pine Bluff. In addition, several free clinics are operating in the market, some of which are sponsored by faith-based organizations. Although community advocates note the important safety net role these free clinics play in their neighborhoods, it is unclear to what degree they meet the health care needs of the community, since they have limited capacity and operate only a few hours per week. The safety net is supported as well by the Arkansas Health Care Access Foundation, which offers low-income uninsured individuals access to about 1,000 physicians in the state who have volunteered to see such patients on an occasional basis. The actual number of referrals is very limited—for example, last year the organization referred approximately two patients per physician.

Improved finances and the limited capacity expansions have strengthened Little Rock's safety net in recent years. Although the state appears to have weathered its current fiscal crisis, continuing budget problems could jeopardize these gains. And the shift by employers of additional costs to their employees may prompt more people to go without health insurance coverage and seek services from the safety net, instead.

Issues to Track

Continuing increases in premiums could result in a no-win situation in Little Rock, with employers shifting more costs to employees, who—as a result—either drop coverage or seek it elsewhere. The market has not been successful in attracting and maintaining plan competitors, and employers believe this limited competition has resulted in higher premiums. However, an unfavorable mix of costs, demographics and local income levels has affected plan competition adversely as well. While the safety net has strengthened over the past two years, it may become increasingly taxed if more people find existing health insurance arrangements unaffordable, or if the state's budget problems worsen.

Key issues to track include:

- Will further premium increases lead more employers to drop health insurance coverage?
- Will further increases in their share of the costs of employer-sponsored insurance lead more employees to seek coverage in the individual health insurance market or forgo coverage altogether?
- Will the exclusive relationship between ABCBS and Baptist continue? If not, what impact will its dissolution have on costs and health plan and hospital competition in the Little Rock market?
- How will the state's budget problems play out? Will the state maintain the status quo of existing public insurance programs? How will the safety net be affected? If the Medicaid

employer buy-in waiver is approved, what impact will it have on the number of uninsured?

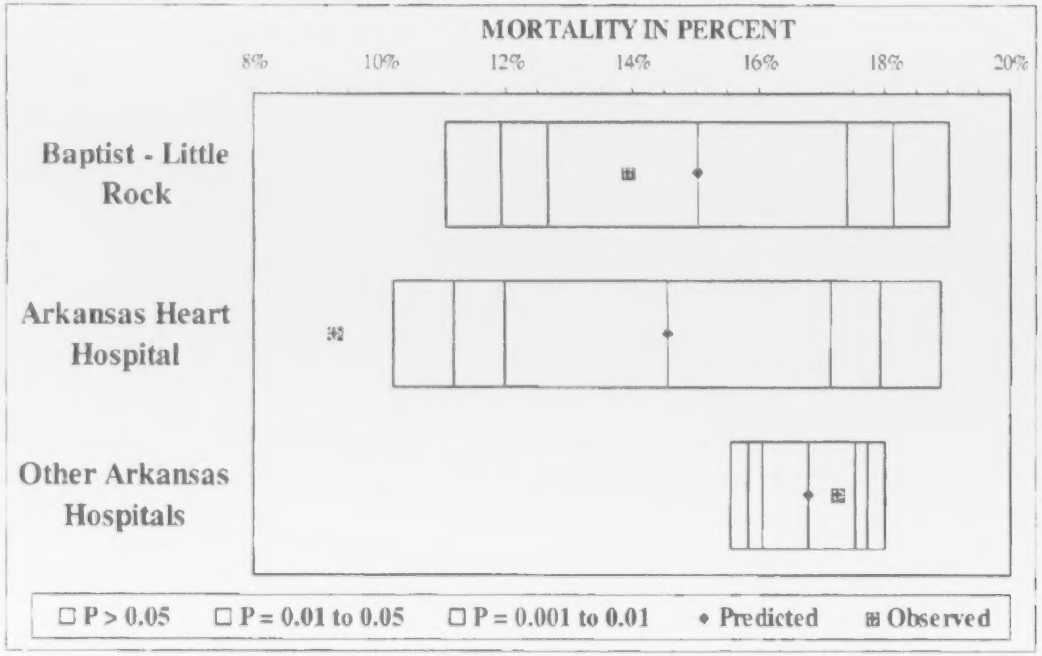
The Community Tracking Study, the major effort of the Center for Studying Health System Change (HSC), tracks changes in the health system in 60 sites that are representative of the nation. HSC conducts surveys in all 60 communities every three years and site visits in 12 communities every two years. This Community Report series documents the findings from the fourth round of site visits. Analyses based on site visit and survey data from the Community Tracking Study are published by HSC in Issue Briefs, Tracking Reports, Data Bulletins and peer-reviewed journals. These publications are available at *www.hschange.org*.

EXHIBIT D TO PETITIONERS' THIRD AMENDED COMPLAINT

[See graphs on next pages]

Risk-Adjusted Mortality

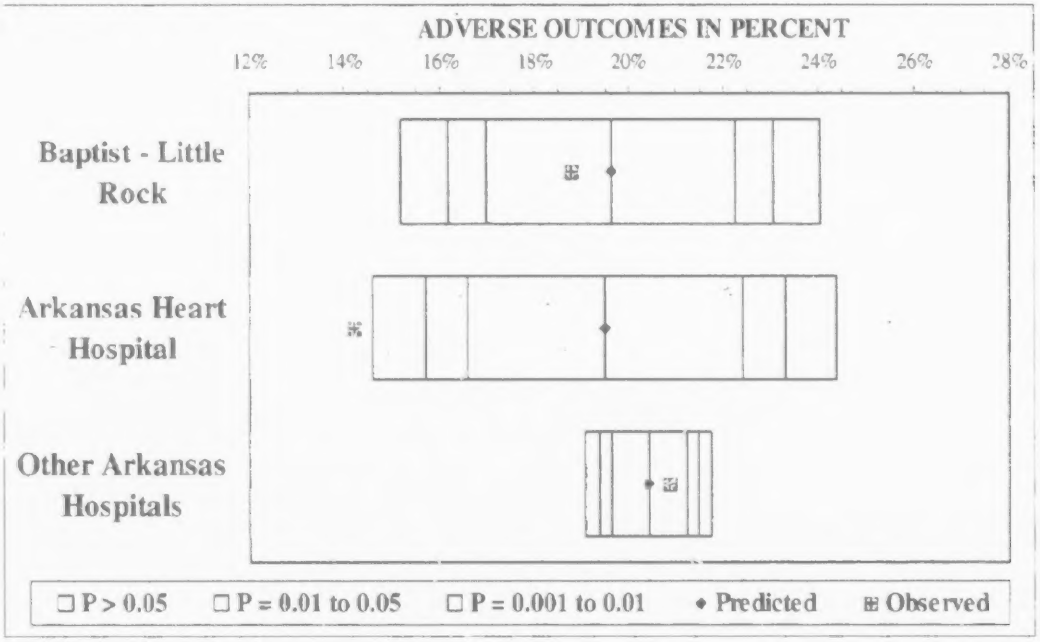
Acute Myocardial Infarction



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Risk-Adjusted Adverse Outcomes

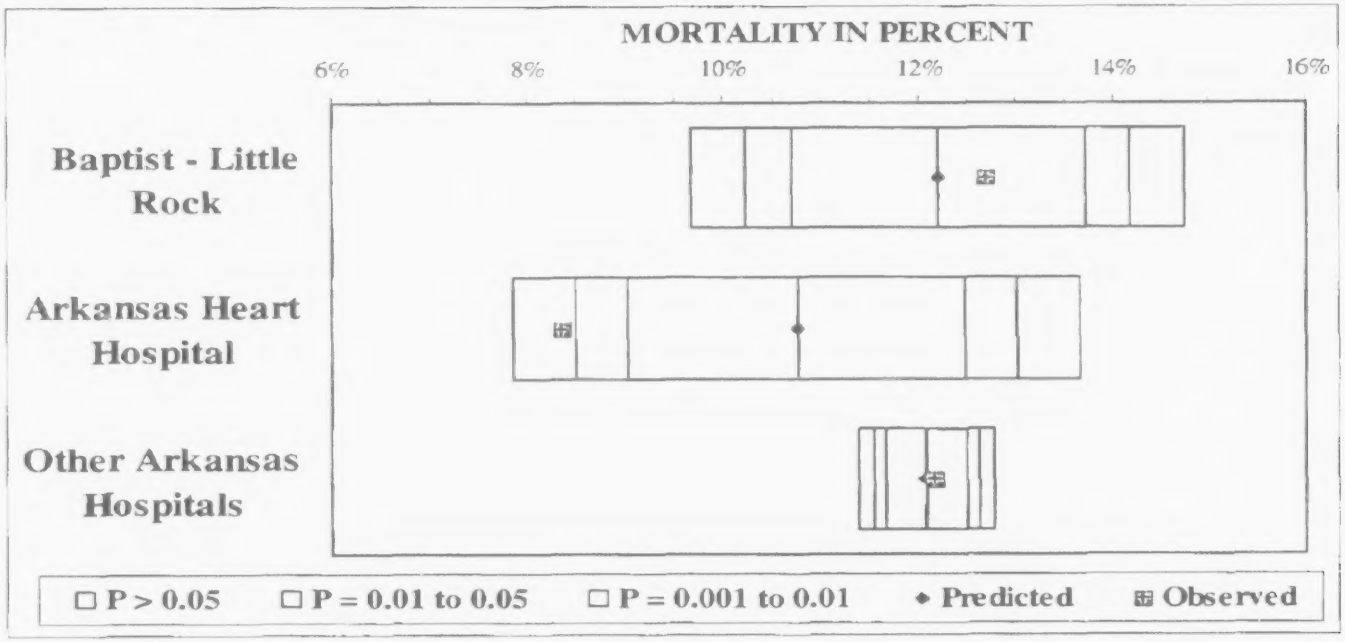
Acute Myocardial Infarction



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Risk-Adjusted Mortality

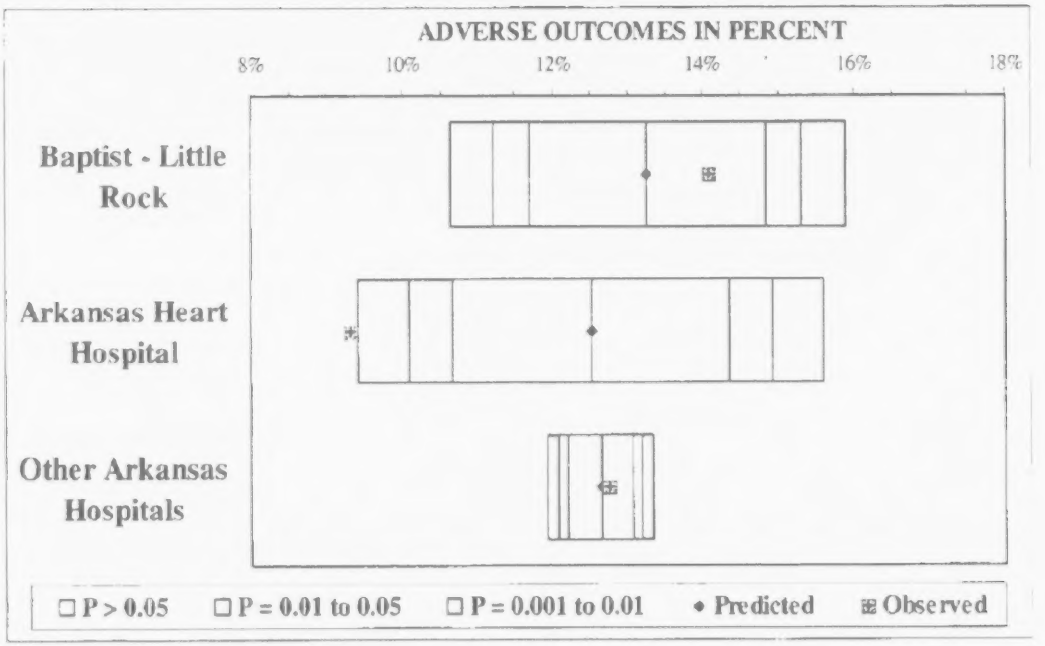
Congestive Heart Failure



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Risk-Adjusted Adverse Outcomes

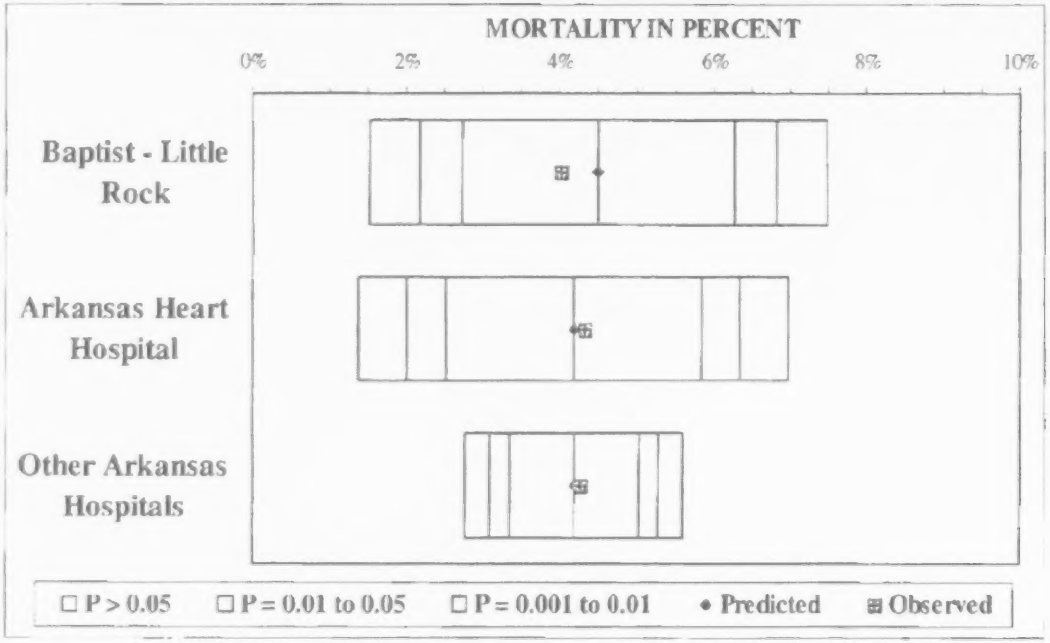
Congestive Heart Failure



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Risk-Adjusted Mortality

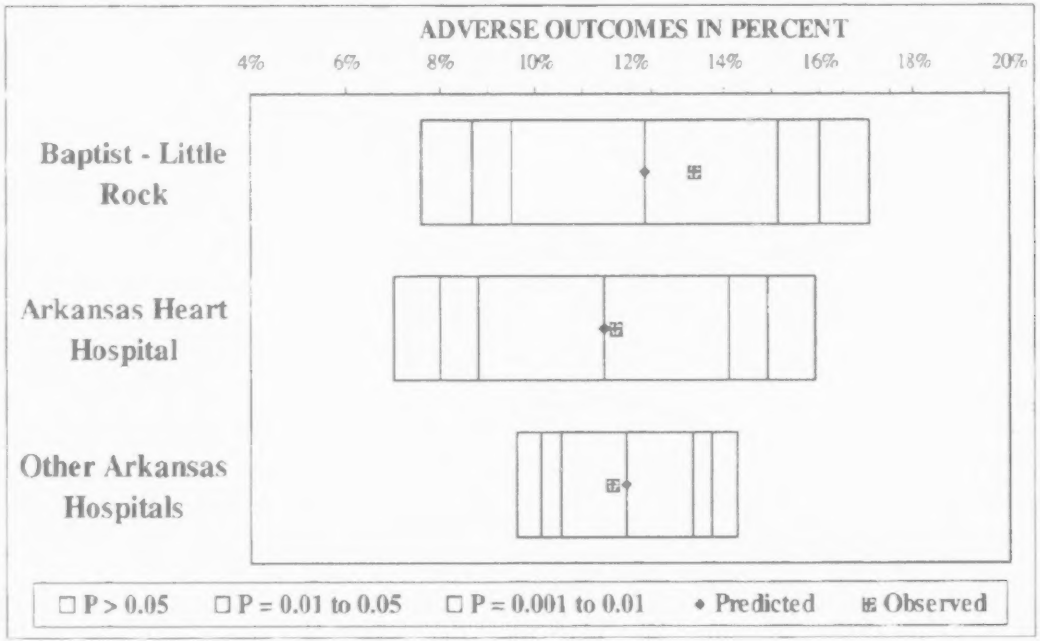
Coronary Artery Bypass Graft Surgery



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Risk-Adjusted Adverse Outcomes

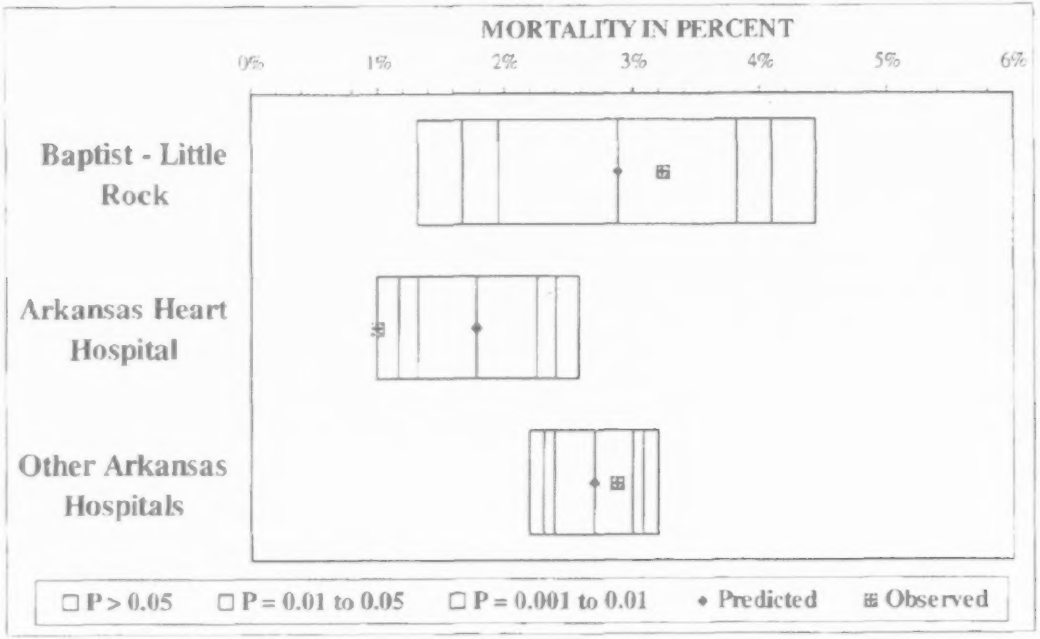
Coronary Artery Bypass Graft Surgery



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Risk-Adjusted Mortality

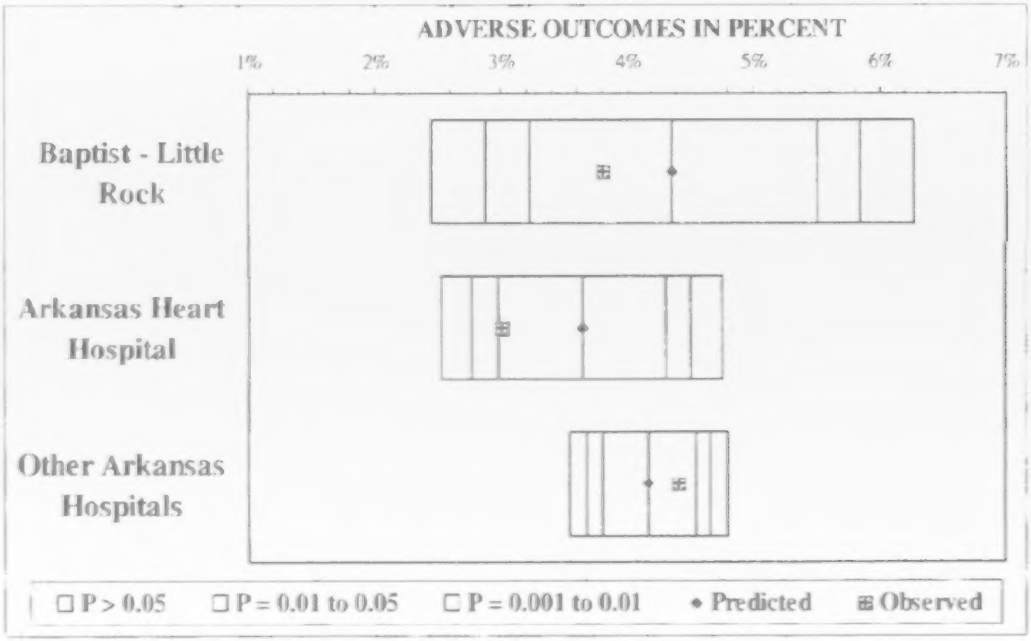
Percutaneous Coronary Intervention



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Risk-Adjusted Adverse Outcomes

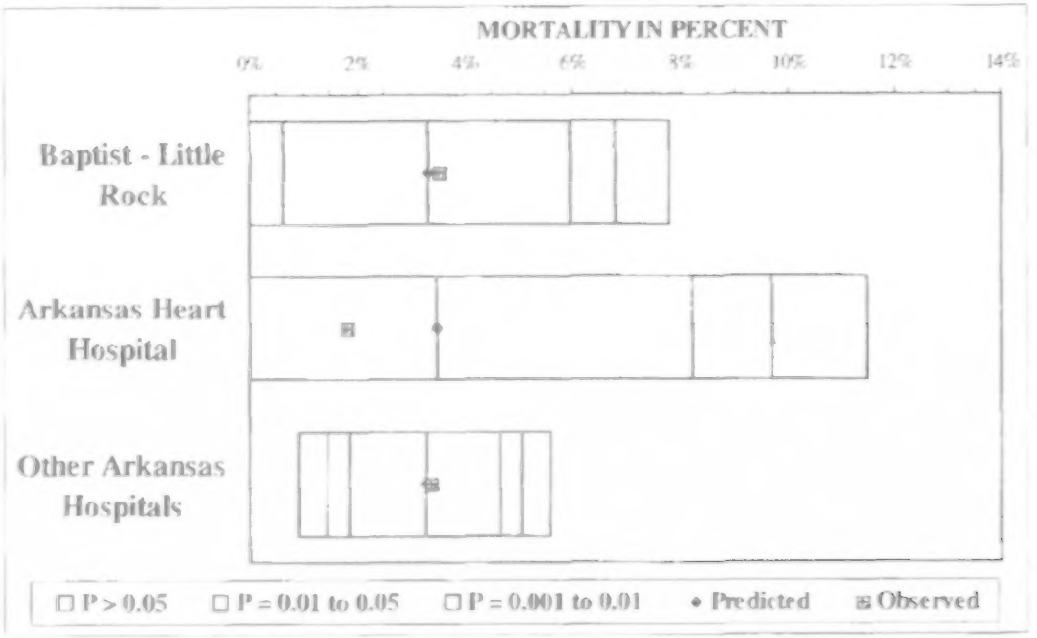
Percutaneous Coronary Intervention



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Risk-Adjusted Mortality

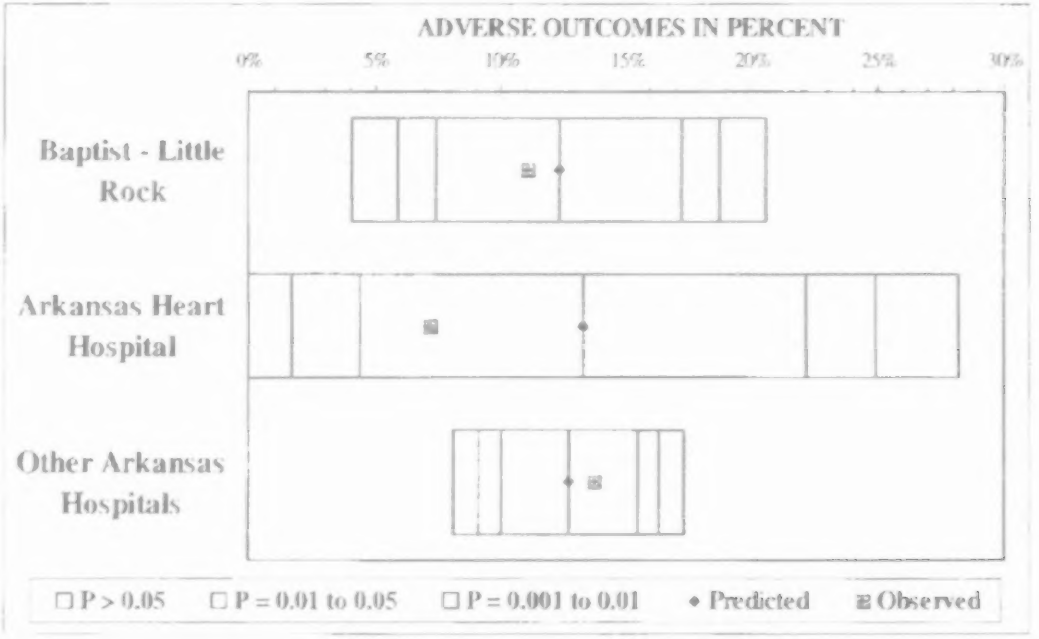
Abdominal Aortic Aneurysm Repair



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Risk-Adjusted Adverse Outcomes

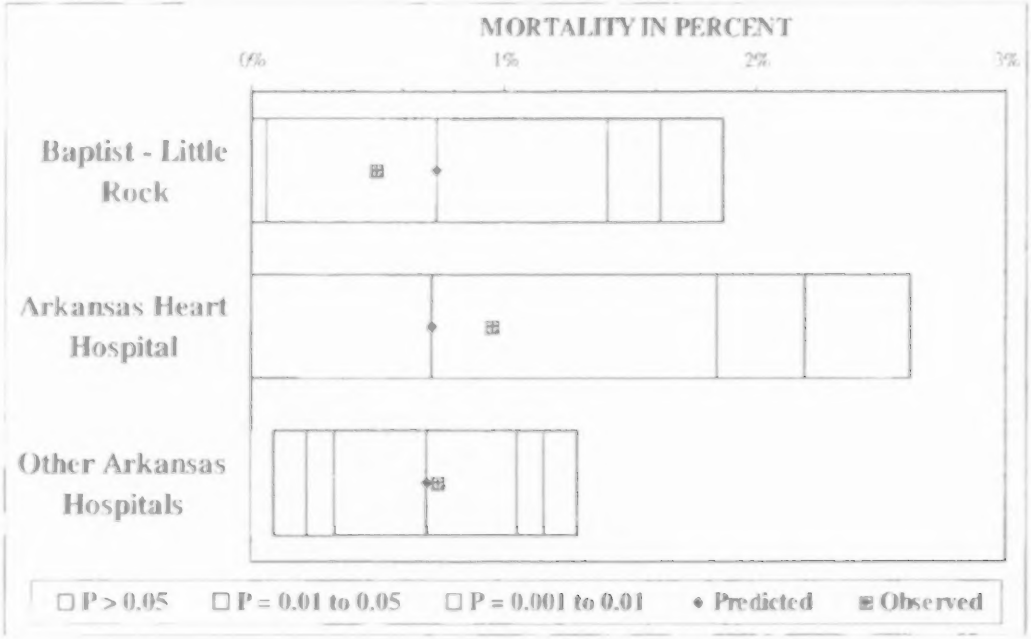
Abdominal Aortic Aneurysm Repair



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Risk-Adjusted Mortality

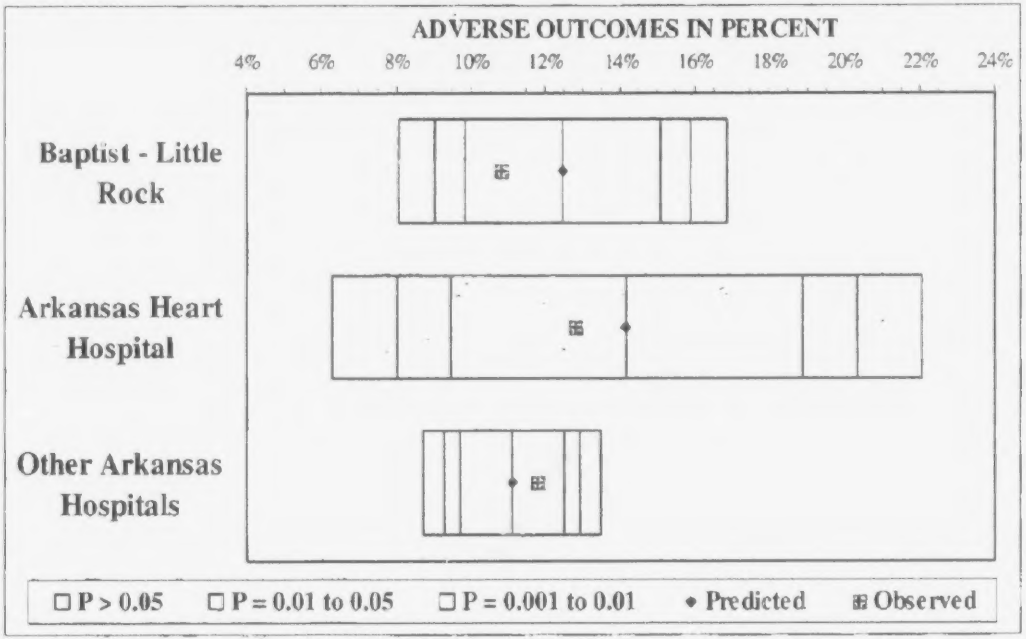
Carotid Endarterectomy



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Risk-Adjusted Adverse Outcomes

Carotid Endarterectomy



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EXHIBIT E TO PETITIONERS' THIRD AMENDED COMPLAINT

[See chart on next pages]

	Arkansas Heart Hospital	Baptist/ Little Rock	Baptist/ NLR	SVI	Southwest Regional Medical Center	Total Discharges by DRG
Volumes by Discharge-Coronary Intensive Care	5,010	4,387	1,654	906	N/A	
Volumes by Discharge-Total	5,010	75,336	21,264	41,379	2,047	
Charges by DRG # of Discharges Low Average High						
Heart Valve Surgery (105)	101 $45,772 $83,611 $121,449	100 $40,122 $109,616 $179,108	24 $68,286 $96,183 $124,079	66 $45,998 $99,952 $153,906	N/A	291
Major Cardiovascular Procedures with Complications (110)	108 $12,378 $39,593 $66,807	181 $17,486 $69,198 $120,907	50 $17,218 $48,696 $80,173	76 $26,402 $67,797 $109,191	N/A	415
Cardiac Cath without Complex Heart Diagnosis (124)	323 $9,888 $18,749 $29,609	255 $9,879 $23,501 $37,122	110 $10,339 $21,390 $32,441	197 $5,236 $32,764 $40,291	N/A	885
Cardiac Cath with Complex Heart Diagnosis (125)	214 $10,605 $18,001 $25,397	329 $11,281 $16,797 $22,311	181 $10,130 $16,191 $22,251	202 $10,938 $16,623 $22,307	9 $24,131 $30,063 $35,995	935
Heart Failure (127)	279 $3,428 $11,175 $18,920	681 $1,547 $19,404 $37,267	347 $3,910 $16,547 $29,182	411 $4,310 $16,262 $28,191	29 $7,018 $21,588 $36,158	1,747
Implant Cardiac Defibrillator (515)	200 $86,371 $112,310 $138,248	116 $54,316 $79,876 $105,435	58 $51,617 $83,289 $114,961	90 $59,919 $75,294 $90,668	12 $56,588 $84,754 $112,919	476

	Arkansas Heart Hospital	Baptist/ Little Rock	Baptist/ NLR	SVI	Southwest Regional Medical Center	Total Discharges by DRG
Bypass and Cath without Major Diagnosis (547)	153 $48,785 $77,464 $106,143	85 $47,484 $97,884 $148,242	46 $45,621 $108,641 $167,660	58 $48,115 $98,101 $148,205	N/A	342
Bypass and Cath with Major Diagnosis (548)	133 $48,598 $66,409 $84,218	107 $59,527 $73,158 $86,738	69 $58,154 $70,917 $83,679	47 $50,473 $71,540 $92,805	N/A	356
Bypass without Cath or Major Diagnosis (550)	247 $31,592 $51,182 $70,772	156 $45,213 $66,401 $85,588	69 $40,855 $54,998 $69,140	128 $34,742 $58,535 $82,328	N/A	600
Arrhythmia Ablation or Coronary Angioplasty w/ Major Diagnosis (555)	503 $17,807 $33,850 $49,892	148 $6,579 $43,695 $80,809	52 $20,417 $39,274 $58,130	132 $28,389 $49,563 $70,736	N/A	835
Drug Coated Stent in Heart Artery with Major Diagnosis (557)	232 $25,055 $36,524 $47,993	210 $23,348 $45,290 $67,231	156 $31,267 $46,100 $60,932	147 $32,454 $49,933 $67,411	15 $49,951 $66,881 $81,810	760
Drug Coated Stent in Heart Artery without Major Diagnosis (558)	427 $22,839 $33,247 $43,653	329 $24,584 $36,253 $47,942	382 $26,261 $38,358 $50,453	370 $28,109 $39,206 $50,302	14 $45,543 $68,451 $91,358	1,522
Total Discharges by Hospital	2,920	2,697	1,545	1,924	79	9,164